I. Introduction
   Acknowledgments

II. MDS 3.0 Section Q Facts

III. What is a Local Contact Agency?
   - Who is ServiceLink?
   - Who is GSIL

IV. MDS 3.0 Section Q Referral Process, Documents & Tools
   - Statement of Understanding
     - Purpose & Goal Statement
     - Referral Process Workflow Action Steps
     - Roles & Responsibilities (NF, SLRC and GSIL)
   - Definition: Best Practice, Business Day, and local contact agency (SLRC) Confirming Resident Interest in Community Living Options
   - Referral Notification Form
     - Non Section Q Referrals

V. Long-Term Care Ombudsman

VI. MDS 3.0 Section Q Case Studies / Stories

VII. Nursing Facility Information/Guidelines
   - MDS 3.0 Section Q National Tool
   - MDS 3.0 Chapter 3
   - MDS 3.0 Section Q Questions and Answers
   - Best Practice tips
   - ServiceLink, Resource Center Contact information

VIII. ServiceLink Resource Network Information / Guidelines
   - Interview Contact Checklist

IX. Other Information
   - State & Federal Assistance
     - Basics Medicaid
     - Basics Medicare
   - Community Based Programs
     - Choices For Independence
     - Money Follows The Person/Community Passport
     - Nursing Facility Transition Program
   - Resource Links
INTRODUCTION

The purpose of this reference manual is to offer guidance for the implementation of Section Q of the MDS 3.0 Resident Assessment Instrument. The manual provides a framework for facilitating person-centered planning with older adults and inspiring person-centered care practices in long-term care facilities. It also provides instruction and examples for the implementation of the Section Q portion of the MDS as well as outlines New Hampshire’s referral process for Section Q referrals.

In support of the success of parties involved with the Section Q referral process, this reference guide includes detailed descriptions of the roles and responsibilities of each party to enhance mutual communication and foster a seamless referral process for identified nursing home residents. Equally, this manual is intended to serve as an orientation tool for staff responsible for the administration of Section Q and compliance with the State’s policy and procedures for MDS 3.0 Section Q referrals.

ACKNOWLEDGMENTS

New Hampshire Bureau of Elderly & Adult Services would like to thank everyone who participated in the development of the referral process for Section Q referrals. We want to express a personal appreciation to the following individuals and organizations for their dedication and contributions for the development of policy and procedures for the referral process, creation of the Section Q referral reference manual and the planning and application of Statewide trainings to nursing facilities, ServiceLink Resource Centers (SLRC), and Granite State Independent (GSIL) staff.

Additionally, special thanks to the nursing facilities and ServiceLink Resource Centers who participated in the pilot trial of the referral process that enabled the identification of best practices for statewide implementation of the process.
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**MDS 3.0 SECTION Q**

**KEY POINTS**

- Section Q includes a question where every resident is asked if s/he would like information or to talk to someone about moving out of the nursing home and back into the community.
- If a resident says yes, the nursing home must initiate care planning and may make a referral to a Local Contact Agency (LCA), which will respond by providing information to the resident about community living services and supports.
- Each resident should be meaningfully engaged in his/her discharge and transition plan.
- The nursing home will continue to be responsible for discharge planning as required by state and federal regulations.

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**MDS 3.0 AND SECTION Q**

On October 1, 2010, the newly revised Minimum Data Set 3.0 (MDS 3.0) went into effect. A number of significant changes were made to this Resident Assessment Instrument in an effort “to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident’s voice by introducing more resident interview items.” Section Q of the MDS 3.0 focuses on Resident Participation in Assessment and Goal Setting. It is designed to identify the resident’s goals and expectations relating to where s/he lives and whether s/he stays in the nursing home or transitions to other living situations. The MDS 3.0 is to be used with all nursing home residents, regardless of payment source.

Through the expansion of Medicaid waivers and state and federal initiatives such as the Money Follows the Person (MFP) program, Medicaid eligible individuals needing long-term care services and supports now have more choice in care options. As a result, nursing home residents who may not have previously been considered as candidates for community living are being reassessed.

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**INFORMATION ABOUT COMMUNITY SERVICES AND SUPPORTS IS REQUESTED BY THE RESIDENT**

If a resident indicates that s/he would like more information about available community-based services and supports, the nursing home is to initiate care planning and will make a referral to a Local Contact Agency (LCAs) if the resident has transition needs that the facility cannot plan for or provide. Each state is required to identify a local contact agency (or agencies) to provide information and transition services to residents who want more information about available community-based services and supports. Examples of agencies that may be designated as LCAs include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), Medicaid Agencies, and Money Follows the Person (MFP) programs, among others.

Specifically, the LCA’s role is to contact individuals referred to them by nursing facilities through the Section Q process, provide timely information about choices of services and supports in the community, and collaborate with the nursing

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facility to organize the transition to community living. LCAs can assist the resident and the nursing home in transition planning to secure/locate housing, home modifications, personal care, and community integration. The nursing home staff and the LCA are expected to work collaboratively to implement transition and discharge planning for the resident.

EACH RESIDENT SHOULD BE MEANINGFULLY ENGAGED IN HIS/HER DISCHARGE AND TRANSITION PLAN

One of the key components of the MDS 3.0 is to increase resident input and participation in the assessment and care planning process. Section Q has been revised to be person-centered, provide the resident the opportunity to express their expectations for care, engage the resident in their discharge planning goals, and initiate a referral to an LCA to provide information and explore the potential for returning to the community.

THE NURSING HOME CONTINUES TO BE RESPONSIBLE FOR DISCHARGE PLANNING IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS

Discharge planning follow-up is already a facility requirement based on federal regulations. There is no change to this requirement because of Section Q. Nursing homes are required to prepare a discharge summary that includes a post-discharge plan of care developed with the resident and his/her family, and that is designed to assist the resident in adjusting to his/her new living arrangements. According to the Guidance to Surveyors, this means that the post-discharge plan should describe the resident’s and family’s preferences for care, and how care and services will be accessed and coordinated. The discharge planning process includes assessing the resident’s continuing care needs and developing a plan to ensure that those needs are met after discharge from the facility.

INvolvement of the Long-term Care Ombudsman Program

An ombudsman may be involved in the Section Q process in several ways that are consistent with current Older Americans Act responsibilities. The long-term care ombudsman is available to assist nursing home residents by resolving complaints related to the transitions process, as well as by providing information and education to consumers, facility staff, and the general public regarding the transitions process. The coordination of services is not a typical ombudsman role.

Examples of ways ombudsmen are likely to be involved:

1. Investigation and resolution of resident complaints related to the transition referral or process,
2. Supporting residents in their decision-making related to transitions,
3. Providing information to consumers and providers (i.e. consultation to individuals) and facility staff (i.e. consultation to facilities) about resident rights and options,
4. Providing educational sessions and materials to consumers and the general public about resident rights and options, and
5. Helping to identify candidates for transitioning to community living and making referrals as appropriate.
6. Local ombudsmen should be alert to issues that recur or are widespread and may call for systemic intervention or advocacy. Such issues should be shared with the State Ombudsman to be addressed with the appropriate entity, such as the Medicaid Agency, Money Follows the Person Program, or the Local Contact Agency.

4 42 CFR 483.20(l)
5 42 CFR 483.20(l)(3)
Local Contact Agencies

What is a Local Contact Agency?
On October 1, 2010, nursing facilities across the country will begin using a new iteration of the Minimum Data Set, called MDS 3.0. The new version includes a revised Section Q designed to identify residents who may be interested in talking to someone about moving back into the community. For these individuals, nursing facility staff will send referrals to Local Contact Agencies, or LCAs. The LCAs will be responsible for contacting residents, discussing options, and assisting interested residents to return to the community.

Who can be a LCA?
Each state Medicaid agency is responsible for selecting and contracting with the organizations that it chooses to serve as LCAs. CMS lists several organizations that can potentially serve as LCAs, including Aging and Disability Resource Centers, Area Agencies on Aging, Centers for Independent Living, and others.

What does this mean for nursing facility residents?
As part of CMS’s revisions to the MDS, a redesigned Section Q will help better assess nursing facility residents’ expectations and interests in returning to the community. As such, the new MDS 3.0 will help nursing facility staff better identify and - with the help of LCAs and other community-based organizations - assist more individuals to explore meaningful opportunities to return to the community. However, the new MDS is just one among many mechanisms for identifying candidates for nursing facility transitions, and the MDS questions alone do not solve some of the biggest challenges in creating community capacity (e.g., housing, behavioral health supports, etc). It is a new tool but not a replacement for other nursing facility diversion and transition efforts.

What would it mean for our organization to become a LCA?
If your organization becomes a LCA, you will establish a formal relationship with the state Medicaid agency (e.g., through contracts or MOUs), execute data-sharing agreements, and respond to referrals from nursing facility staff to provide options counseling and transition assistance. Based on the experiences of the states that pilot tested MDS 3.0, the volume of referrals was not overwhelming, but the implementation of MDS 3.0 will vary from community to community. If you become a LCA, you will need to ensure sufficient staffing levels and establish workflow processes to respond to referrals within a short timeframe (e.g., one week), as may be specified in your agreement with the state Medicaid agency.

What should I do if I want my organization to become a LCA?
Your state Medicaid agency will decide which organization(s) can become LCAs. We recommend meeting with state Medicaid officials to discuss their plans for identifying LCAs and your capabilities to support nursing facility transitions.

You should consider several important issues in deciding whether to pursue becoming a LCA:
- Do you have relationships with area nursing facilities?
- Have you established protocols for providing options counseling and transition assistance to nursing facility residents?
- Do you have partnerships with other organizations that can help support nursing facility transitions (e.g., AAAs, CILs, agencies serving people with developmental disabilities or mental illnesses, public housing authorities)?
- Have you established relationships with community-based service providers that could help meet the needs of individuals transitioning out of nursing facilities?
- Do you have trained, qualified staff who understand person-centered planning, can assist in obtaining accessible housing, and have experience supporting people through the discharge process?

LCAs will have important roles under MDS 3.0. However, whether you are a LCA or not, you can still continue the work you may already be doing to help nursing facility residents return to the community.

Is there funding available for this initiative?
CMS has not designated any funding specifically to support the activities of a LCA. However, there are multiple funding streams that currently support the functions that would be performed as a LCA, including, funding associated with the federal Money Follow the Person initiative, Medicaid administrative matching funds, Medicaid targeted case management benefits, Older Americans Act Title III funding, Rehabilitation Act funding, and others.

Where can I get more information?
We will post additional information on the www.adrc-tae.org website as it becomes available. You can also submit questions or comments to mdsformedicaid@cms.hhs.gov.
The New Hampshire ServiceLink Resource Center (SLRC) Network, the State’s Aging and Disabilities Resource Center Program was established in 2000 to provide information and assisted referrals to anyone seeking help in accessing long term care for elderly and for adults with chronic illness or conditions. ServiceLink is a free information, referral, and assistance resource center, with local offices in 13 communities and with many satellite offices throughout New Hampshire. ServiceLink answers questions and connects users to the appropriate services that support healthy and independent living.

Each ServiceLink employs staff in the role of Center Manager, Information and Referral Specialist, Family Caregiver Support Specialist and SHIP/SMP Coordinator. ServiceLink also employs staff in the role of a Long-Term Support Counselor, who has the primary responsibility of working with individuals and families to identify needs and to fully explore health care and long-term care options available in that community. Through a supported decision-making model, ServiceLink also provides assistance to those individuals who, for a variety of reasons, need help in making decisions for themselves or for family members about long-term care.

ServiceLink also assists consumers to navigate, what is often, a complex and bewildering process of applying for services at a time when they must deal with their own health care crises or on behalf of a family member or other person. For these individuals, ServiceLink is the starting point for accessing long-term care services and supports, including Medicaid nursing home care and the Medicaid Waiver services. The model has demonstrated that individuals can access the services and supports they need more quickly.

However, ServiceLink referrals are not limited to Medicaid applicants and recipients only. ServiceLink is the connection for linking people to Social Services Block Grant services, Older Americans Act services, privately funded services, and services which are unique to a regional service area, regardless of an individual’s income.

The ServiceLink Resource Center team are assisted by web-based tools and supported by community Division of Family Assistance family services specialists, Bureau of Elderly and Adult Services long term care nurses, Adult Protective Services social workers, and Home and Community Based Care case managers. This team works in partnership with community leaders and providers to develop solutions to service gaps.
The ability to live life on your own terms is more than a basic need. It is a very basic human right. Granite State Independent Living recognizes the fact all of us will need some type of support in the course of our lives. As a statewide nonprofit organization, we provide tools and resources you can use to participate as fully as you choose in your life, family and community, just like everyone else.

- Access Modification Services
- Advocacy
- Attendant Care Registry
- Benefits Planning
- Deaf and Hard of Hearing Services
- Employment Services
- Information and Referral
- Peer Support
- Personal Care Attendant Services
- Personal Care Services Provider
- Home Care Service Provider
- Sign Language Interpreter Services
- Skills Training
- Telecommunications Equipment
- Ticket to Work
- Wheelchair-Accessible Transportation

Who can use our services?
Seniors, adults and youth with physical, sensory, mental or cognitive disabilities which limit their ability to function independently in the community or are a barrier to obtaining and maintaining satisfying employment are encouraged to contact us.
We were founded on the principle of consumer control

Founded in 1980, Granite State Independent Living is guided by a principle called consumer control—we believe the person with a disability is in the best position to make the decisions that affect his or her life.

Every service we deliver is based on this principle and every staff person at Granite State Independent Living is committed to this philosophy. In fact, a majority of our board and staff members are individuals with disabilities—people who understand that YOU belong in the driver’s seat of your life.

Start living life on your terms.

We provide a positive team approach to helping you meet your goals for independent living.

About Granite State Independent Living

A statewide nonprofit, Granite State Independent Living recognizes the fact that all of us will need some type of support in the course of our lives. We offer tools and resources so that individuals can participate as fully as they choose in their lives, families and communities. Our mission is to promote life with independence through advocacy, information, education and support.
Protocols For MDS 3.0 Section Q Implementation

Summary of the Policy

Under the code of federal regulations, 42 CFR 483.20 nursing homes that participate in the Medicare or Medicaid programs must complete the Minimum Data Set (MDS) assessment for all residents admitted to the facility. The Center for Medicare and Medicaid Services (CMS) has made changes to the MDS and has added a new requirement under Section Q. Nursing homes are required to make a referral to the designated local contact agency for any resident who, in response to the MDS questions, indicates he/she wishes to talk to someone about returning to the community.

Background

The Americans with Disabilities Act of 1990 and the 1999 Olmstead decision state that residents have a right to receive care in the least restrictive setting. Providing residents with choices through information about care options and supports that are available to meet their preferences and needs helps to ensure those residents have the opportunity to access the least restrictive setting appropriate to them.

Designation of the Local Contact Agency

In support of the MDS 3.0, all states were asked by CMS to identify Local Contact Agency for nursing home staff to refer individuals who (answer “Yes”) are interested in learning more about their community living options. ServiceLink, NH’s statewide network of community-based connection for elders, adults with disabilities and their families serves as the Local Contact Agency for NH nursing facilities for Section Q Referrals. ServiceLink staff will provide community resource information for individuals interested in transitioning back to the community. The State of New Hampshire identifies Granite State Independent living (GSIL) as a resource to ServiceLink. GSIL is a statewide nonprofit organization whose mission is to promote life with independence for people with disabilities and those experiencing the natural process of aging through advocacy, information, education and support.

Goal for successful Section Q Referral

- Maintain collaboration
- Support the resident’s expressed interest
- Provide information
- Collaborate with nursing facility on discharge planning

MDS 3.0 Section Q. Referral Workflow Action Steps

1. The Nursing Facility (NF) conducts Section Q of the MDS 3.0. The resident answers, “Yes, I want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community” (Q0500).
2. Within three (3) business days of the individual’s request, the NF shall generate the referral to their local ServiceLink Resource Center (SLRC) using the standardized referral notification tool.
3. Within the same three (3) business days of the resident answering “Yes” to the Q0500 question, the NF will give the resident a SLRC brochure to inform him/her who will be coming to visit to talk about community living options.
4. SLRC will confirm with the NF receipt of the referral SLRC shall verbal “confirm the resident’s interest” in speaking to a third party about available community living supports, and schedule a face-to-face visit.
5. Within 10 business days of receiving the referral from the NF, SLRC will visit with the resident. This first face-to-face will be a meet and greet. This visit will be a time to gather information about the resident’s desires and community support needs.
6. SLRC will inform the NF the first face-to-face with the resident has occurred and SLRC had shared an overview of available community living supports. If not already determined, SLRC will confirm if the resident would like to meet again to discuss community options specific to the resident’s desires and needs.
7. If the resident wants a second face-to-face with a SLRC to learn additional information about community living options, SLRC will gather the needed information from the resident’s family, circle of support and NF.

8. The NF and SLRC will participate in conversation(s) with the resident, family members, and the resident’s circle of support to learn if the resident wants to pursue community living options or end the referral process.

9. Within 10 business days of the first face-to-face with the resident, SLRC will conduct the second face-to-face meeting with the resident to discuss community living options available specific to the resident’s desires and needs.

10. If the resident decides to end the process, both SLRC and the NF will document the date and reason (if provided) why the process ended.

11. If the resident decides to pursue community living, the NF will make the referral to the applicable provider agency chosen by the individual.
   a. For Example: For GSIL’s Nursing Facility Transition Program, GSIL will work with the NF to facilitate a transition plan using the person-centered tool.

Nursing Facility Role and Responsibilities

1. Administers MDS 3.0 Section Q at the frequency and manner as directed by CMS.

2. Transmits referral to Lead Local Contact Agency (SLRC) within three (3) business days of individual responding “Yes” to Q0500.
   a. Documents in resident’s medical record if (and why) referral is not made within three (3) business days.

3. Within the same three (3) business day period, NF provides individual with information to support the role of the LCA who will be contacting him/her.

4. Engage in discussion as needed with LCA.

5. Maintains collaboration between facility and LCA to support residents expressed interest in being transitioned

6. Coordinates with LCA and individual to arrange face-to-face visit.

7. Supports the resident in achieving his/her highest level of functioning by participating in conversation with the individual, family (circle of support), and LCA to learn if individual wants to move forward or end referral process.

8. If already receiving Medicaid funded LTC, a change of status form should be sent to BEAS. The information provided by BEAS will be a tool for coordinating potential transition to community through the Community Passport / Money Follows the Person program.
   a. Refer to NHPCT/Section Q Reference Manual for Community Passport/Money Follows the Person program description.

9. Submits referral(s) to community provider(s) (chosen by the resident) coordinates and assists community support provider(s) as needed to facilitate a transition to the community.

10. Documents in individuals Plan of Care all actions taken by the Nursing Facility and subsequent decisions of individual on their decision to transition to the community.

11. Per facility protocol, executes follows-up practice with individual after discharged into community living.

12. Adheres to confidentiality and Health Insurance Portability and Accountability Act (HIPAA) requirements.

13. Participates in available training pertaining to the NHPTC.

ServiceLink Resource Center Role and Responsibilities

1. Confirms with the nursing facility receipt of referral notification document, confirms interest with both resident and facility by making a telephone contact to resident or residents preferred contact, and schedule an appointment with the resident, with three (3) business days of receiving referral.

2. Documents in Refer & (in accordance with Refer 7 Section Q Guidelines), that a Section Q referral notification received from NF.
   a. Establishes file for referral notification.
   b. Documents if timeline not met for confirming receipt of referral, confirming interest and scheduling appointment with the resident.

3. Refers to GSIL for consult as needed
4. Conducts face-to-face visit, with the individual and informs him/her of community living options.
   a. Document in refer 7 (in accordance see #2) if face-to-face not conducted within 10 working days of receiving referral.
5. Informs NF that face-to-face visit has occurred and information about community living options has been provided to the resident.
6. Coordinates with NF (and other team members as necessary) to explore community care options/supports. Provides information on these options as needed.
7. Participates in conversation with the resident, family (circle of support), and NF to learn if resident wants to move forward or end referral process.
8. Assesses resident for potential eligibility for Community Passport/Money Follows the Person Program.
   a. Refer to NHPCT/Section Q Reference Manual for Community Passport/Money Follows the Person Program description/details.
   b. If additional information is needed, contacts Community Passport/Money Follows the Person Program directly.
9. Supports nursing facility in conducting appropriate care planning to determine if transition back to the community is possible.
10. Refers to GSIL for additional consult (if needed) and/or Transition Coordinator based on the GSIL Nursing Facility Transitions and Life Skills Training Program.
    a. Refer to NHPCT/Section Q Reference manual for Nursing Facility Transition Program details.
11. Documents in Refer 8 (in accordance see #2) all Section Q activities and actions taken by SLRC and resident’s decision regarding their transition to community.
12. Adheres to Confidentiality and Health Insurance Portability and Accountability Act requirements.
13. Participates in available training pertaining to the NHPCT/Section Q Referral Process for New Hampshire.

QUESTIONS/COMPLAINTS REGARDING MDS SECTION Q REFERRALS CAN BE DIRECTED TO:

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Bureau of Elderly of Adult Services
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Don Rabun
Long-Term Care Ombudsman
Bureau of Elderly and Adult Services
P: (603) 271-4704
F: (603) 271-5574
1-800-442-5640
drabun@dhhs.state.nh.us
Statement of Understanding
Between NH Nursing Facilities and NH Section Q Local Contact Agency

Purpose
This Statement of Understanding is between New Hampshire Qualified Nursing Facilities and New Hampshire Local Contact Agency Network concerning the roles and responsibilities when generating and processing a MDS 3.0 Section Q referral.

Background
The State of New Hampshire strives to ensure that all individuals have the right to receive long-term services and supports in the least restrictive and most integrated settings. This right became law under the American with Disabilities Act (1990) and in 1999 was further interpreted by the U.S. Supreme Court in the Olmstead vs. L.C. decision. New Hampshire’s journey to rebalance its long-term care system for older adults began in 1995 when the State legislature enacted a moratorium on new nursing home beds.

On October 1, 2010, the Centers for Medicare & Medicaid Services (CMS) launched MDS 3.0. This newly revised resident assessment tool is a very different document both in substance and in philosophy. It approaches the nursing facility resident assessment from a more person-centered planning perspective in which residents are able to take a more active role in determining their individual service plan. One of the major changes to MDS 3.0 is Section Q, or the “referral section. The original Section Q was dependent on others to respond to the question. The MDS 3.0 Section Q actively engages residents to determine their goals in pursuing going back to a community residence or remaining in a nursing facility setting.

In support of the MDS 3.0, all states were asked by CMS to identify LCA(s) for nursing home staff to refer individuals who (answer “Yes”) are interested in learning more about their community living options. ServiceLink, NH’s statewide network of community-based connection for elders, adults with disabilities and their families serves as the Local Contact Agency for NH nursing facilities for Section Q Referrals. ServiceLink staff will provide community resource information for individuals interested in transitioning back to the community. The State of New Hampshire identifies Granite State Independent Living (GSIL) as a resource to ServiceLink. GSIL is a statewide nonprofit organization whose mission is to promote life with independence for people with disabilities and those experiencing the natural process of aging through advocacy, information, education and support.

Nursing Home Person-Centered Transition to Community Living Goals:

Goal 1: Stakeholders will collaborate to share best practices, leverage existing networks, review current practices and resources, share expertise and perspectives with the aim of creating a seamless referral process for nursing home resident referrals and transitions to the community

Goal 2: Develop policy and protocols that foster established systems pathways and generate new ones for MDS Section Q referrals that will be standardized for use by all qualified nursing facilities and Local Contact Agency

Goal 3: Strengthen the education and awareness of community service supports, and resources available to residents in the local community of their choice by educating nursing home discharge planners through increased outreach efforts to nursing facilities discharge planners who will be making MDS Section Q referrals to the Local Contact Agency.

Goal 4: Create a process that will foster communication and sustain on-going partnerships between nursing homes and Local Contact Agency to get residents the available resources they need to live in the community.
Section Q Workflow Action Steps

**Step 1**
The Nursing Facility (NF) conducts Section Q of the MDS 3.0. The resident answers, “Yes, I want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community” (Q0500).

**Step 2**
Within three (3) * business days of individual’s request, the NF shall generate the referral to their local ServiceLink Resource Center (SLRC) using the standardized referral notification tool.
- If the *“Best Practice” established timeline was not met, the NF shall document in the individual’s record/file with an explanation.

**Step 3**
Within the same three (3) business days of the resident answering “Yes” to the Q0500 question, the NF will give the resident a SLRC brochure to inform him/her who will be coming to visit to talk about community living options.
- The NF will document the date the brochure was given to the individual.

**Step 4**
SLRC will confirm with the NF receipt of the referral within three (3) business days of receiving the referral.
SLRC shall verbally *“confirm the resident’s interest” in speaking to a third party about available community living supports, and schedule a face-to-face visit.
- If the “Best Practice” established timeline was not met, SLRC will document the reason why.

**Step 5**
Within 10 business days of receiving the referral from the NF, SLRC will visit with the resident. This first face-to-face will be a meet and greet. This visit will be a time to gather information about the resident’s desires and community support needs.
- If “Best Practice” established timeline was not met, SLRC shall document, in Refer 7, the reason why.
- SLRC will consult with GSIL as needed.

**Step 6**
SLRC will inform the NF the first face-to-face with the resident has occurred and SLRC had shared an overview of available community living supports. If not already determined, SLRC will confirm if the resident would like to meet again to discuss community options specific to the resident’s desires and needs.
- SLRC or NF will contact GSIL for consultation as needed.

**Step 7**
If the resident wants a second face-to-face with a SLRC to learn additional information about community living options, SRLC will gather the needed information from the resident’s family, circle of support and NF.

**Step 8**
The NF and SLRC will participate in conversation(s) with the resident, family members, and the resident’s circle of support to learn if the resident wants to pursue community living options or end the referral process.

**Step 9**
Within 10 business days of the first face-to-face with the resident, SLRC will conduct the second face-to-face meeting with the resident to discuss community living options available specific to the resident’s desires and needs.

**Step 10**
If the resident decides to end the process, both SLRC and the NF will document the date and reason (if provided) why the process ended.

**Step 11**
If the resident decides to pursue community living, the NF will make the referral to the applicable provider agency chosen by the individual.

For Example:
- For GSIL’s Nursing Facility Transition Program, GSIL will work with the NF to facilitate a transition plan using the person-centered tool.
**Nursing Facility (NF)**

1. Administers MDS 3.0 Section Q at the frequency and manner as directed by CMS.

2. Transmits referral to local ServiceLink Resource Center (SLRC), the Local Contact Agency for MDS 3.0 Section Q Referrals within 3- business days of resident responding “Yes” to Q 0500.
   a. Documents in resident’s Medical Record if referral is not made to LCA within 3 business days of resident request.

3. Within the same 3-business day period, NF provides resident with SLRC brochure to inform him/her who will be coming to visit to talk about community living options.

4. Engages in discussion as needed with SLRC.

5. Maintains collaboration between facility and SLRC to support residents expressed interest in being transitioned.

6. Coordinates with SLRC and resident to arrange fact to face visit.

7. Supports the resident in achieving his or her highest level of functioning by participating in conversation with the individual, family (circle of support), and SLRC to learn if individual wants to move forward or end referral process.

8. If already receiving Medicaid funded LTC, a **change of status form** should be sent to BEAS. The information provided by BEAS will be a tool for coordinating potential transition to community through the Community Passport/ Money Follows the Person Program.
   a. Refer to NHPCT/ Section Q Reference Manual for Community Passport/Money Follows the Person program description/details

9. **Submits** referral(s) to community provider(s) (chosen by the resident), coordinates and assists community support provider(s) as needed to facilitate a transition to the community.

10. Documents in resident’s Medical Record all Section Q activities and actions taken by the NF and resident’s decision regarding their transition to community.

11. Per facility protocol, executes follows-up practice with individual after discharged into community living

12. Adheres to confidentiality and Health Insurance Portability and Accountability Act requirements.

13. Participates in available training pertaining to the NHPCT/Section Q Referral Process for New Hampshire.
1. Confirms with the nursing facility receipt of referral notification document, confirms interest with both resident and facility by making a telephone contact to resident or residents preferred contact, and schedule an appointment with the resident, within 3 business days of receiving referral. *

2. Documents in Refer 7 (in accordance with Refer 7 Section Q Guidelines), that a Section Q referral notification received from NF.
   a. Establishes file for referral notification.
   b. Documents if timeline not met for confirming receipt of referral, confirming interest and scheduling appointment with the resident.

3. Refers to GSIL for consult as needed.

4. Conducts face to face visit, with the individual and informs him/her of community living options
   a. Document in refer 7 (in accordance see # 2) if face to face not conducted within 10 working days of receiving referral.

5. Informs NF that face-to-face visit has occurred and information about community living options has been provided to the resident.

6. Coordinates with NF (and other team members as necessary) to explore community care options/supports. Provides information on these options as needed.

7. Participates in conversation with the resident, family (circle of support), and NF to learn if resident wants to move forward or end referral process.

8. Assesses resident for potential eligibility for Community Passport /Money Follows the Person Program
   a. Refer to NHPCT/Section Q Reference Manual for Community Passport/Money Follows the Person Program description/details.
   b. If additional information is needed, contacts Community Passport/Money Follows the Person Program directly.

9. Supports nursing facility in conducting appropriate care planning to determine if transition back to the community is possible.

10. Refers to GSIL for additional consult (if needed) and/or Transition Coordinator based on the GSIL Nursing Facility Transitions and Life Skills Training Program.
    a. Refer to NHPCT/Section Q Reference Manual for Nursing Facility Transition program details.

11. Documents in Refer 7 (in accordance see # 2) all Section Q activities and actions taken by SLRC and resident’s decision regarding their transition to community.

12. Adheres to Confidentiality and Health Insurance Portability and Accountability Act requirements.

13. Participates in available training pertaining to the *NHPCT/Section Q Referral Process for New Hampshire.

*The level and type of response needed by an individual is determined on a resident-by resident basis.
Granite State Independent Living, Inc. (GSIL) Consultant to Service Link Resource Center Network for Section Q Referrals

1. Serves in consulting role for SLRC through the referral process as needed.

2. Provides SLRC, resident and family (circle of support) with additional information as needed.

3. Responds to referrals for consult and/or to participate as Transition Coordinator based on the GSIL Nursing Facility Transitions and Life Skills Training Program.

4. If transition to community is possible and the resident is willing and motivated to engage in the Nursing Facility Transition Program process with their coordinator, GSIL will participate in conversation with the SLRC, resident and family (circle of support), and NF to support care planning.

5. Reports on results of referrals and transitions to SLRC and BEAS.

6. Adheres to confidentiality and Health Insurance Portability and Accountability Act requirements.

7. Participates in available training pertaining to the *NHPCT/Section Q Referral Process for New Hampshire.

*Nursing Home Transition to Person-Centered Transition to Community Living
# NURSING HOME TRANSITION TO COMMUNITY LIVING

## MDS 3.0 SECTION Q REFERRAL FORM

### I. NURSING HOME

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
</tr>
<tr>
<td>Name of Contact</td>
<td>Title</td>
</tr>
<tr>
<td>E-mail Address</td>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

### II. INDIVIDUAL BEING REFERRED

<table>
<thead>
<tr>
<th>Name of Individual</th>
<th>Room Number</th>
<th>Date of Birth</th>
<th>SEX</th>
<th>County of Preference for Relocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number to reach Individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Has verbal consent been obtained?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Does this Individual have a <strong>legal guardian</strong>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Does this resident have an <strong>activated Power of Attorney for Health Care (POAHC)</strong>?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who was consent obtained from?</th>
<th>Individual</th>
<th>Legal guardian / Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Legal Guardian / Activated POAHC</td>
<td>Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Payer for Nursing Home Stay (Check all that apply)</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Private Insurance</th>
<th>Private Pay</th>
</tr>
</thead>
</table>

### III. Individual's Designated Contact Person

(complete if the Individual is competent and requests another individual (e.g., family member, friend) be contacted.)

<table>
<thead>
<tr>
<th>Name of designated contact person</th>
<th>Relationship to resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Mailing Address</td>
<td>City</td>
</tr>
<tr>
<td>E-mail address</td>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

Verbal consent telephonically received by: Date |

Nursing Facility witness to verbal consent: |

### ADDITIONAL INFORMATION

(Other referrals made, special considerations, information not reflected on this form)
The following guidance is provided to you and supported by NH Department of Health and Human Services

1. Completion of this form is required under federal regulation 42 CFR 483.20, which requires federally certified nursing homes to complete the Minimum Data Set (MDS) assessment for all individuals admitted to a skilled nursing center (SNC)/Intermediate Care Facility (CFI). SNC’s and ICFs are required to make a referral to the Local Contact Agency (LCA) for any individual who, in response to the MDS Section Q questions, indicates that he/she wishes to talk with someone about returning to the community.

2. Within three (3) business days of completing Section Q of the MDS, submit a completed copy of this form to the Local Contact Agency (ServiceLink Aging and Disability Resource Center (SLRC), serving the area where the nursing home is located. Please refer to your MDS 3.0 Training Material or the SLRC website servicelink.org for the fax, phone, and e-mail address to your Local Contact Agency.

3. Keep a copy of the referral form in the Individual’s medical record.
Nursing Facility Social Service Duties and Best Practices

Nursing home social workers provide many services to both residents and family members, working on behalf of the resident. In addition to many other duties, the social worker works closely with doctors and nursing staff to develop specific care plans based on the needs of the resident.

Medicare/Medicaid Liaison

A nursing home social worker acts as a liaison between the resident and Medicare and Medicaid. When a resident has no other health insurance benefits to pay for the nursing home stay, the social worker assists in gathering, preparing and submitting paperwork to the Medicare and Medicaid departments for approval. The social worker may also assist the resident or family in applying for other special programs, such as the Medicare drug plan and community waivers.

Psychosocial Care

A social worker provides psychosocial care for the nursing home residents and their families. Social workers first assess the residents' mental health and screen for depression, and upon arrival to the nursing home. Throughout the resident's stay, the social worker provides counseling on a wide variety of issues, such as adjustment to the nursing home, as well as grief and loss.

Discharge Planning

Nursing Facility social workers perform discharge-planning duties for residents. Discharge-planning involves preparing resources for and speaking with the resident and his/her family about changes and coping strategies after discharge from the nursing facility. The social worker may arrange for home health nurse visits and follow-up care with doctors. The social worker also gives advice on adjusting to home life, especially if the resident has had an extended nursing facility stay.

Resident Satisfaction

Resident satisfaction plays a large role in the success of any nursing facility. Social workers ensure that nursing facility residents are comfortable and secure during their stay. They respond to and resolve both resident and family complaints. Social workers make changes to residents' rooms, finding private rooms for some residents as needed. Other issues include ensuring fair treatment to residents by the nursing staff and finding appropriate recreational activities for residents.

Staff Training

Social workers train staff on issues related to the resident and his/her family. The social worker discusses, with the nursing staff, the emotional needs of both the resident and family. In addition, the social worker may conduct training sessions on issues such as identifying physical and/or emotional abuse. Social workers may also plan interventions, as needed, for residents who display behavioral symptoms or problems.
The Office of the Long-Term Care Ombudsman (OLTCO) is responsible for receiving, identifying, investigating, and resolving complaints or problems made by, or on behalf of, residents of long-term care facilities that relate to the health, safety, welfare, and rights of residents. As a program under the Older American’s Act, the OLTCO serves those aged sixty (60) and older. The OLTCO refers most residents under the age of sixty (60) to other advocacy programs that can assist them. OLTCO advocates for long-term care residents when there are no other advocates that can assist the long-term care resident under the age of sixty (60).

The Office of the Long Term Care Ombudsman is primarily focused on the rights of those who are aged sixty (60) and older. Through facilitation, team work, empowerment, and person-centered planning and advocacy, the members of the Office of the Long Term Care Ombudsman strive to resolve issues and complaints to the satisfaction of the resident.

The Office of the Long-Term Care Ombudsman activities are organized around three major areas, Prevention, Intervention and Advocacy.

**Prevention:**
- Education and consultation to both staff and individuals on issues affecting residents in long-term care facilities;
- Problem solving before a crisis occurs and making recommendations to facility administration and staff concerning recommended changes in policy, practice and procedures;
- Information and referral to help connect persons to the best available resources and information; and
- Regular visits to long-term care facilities by trained volunteers to identify and report serious concerns or to resolve issues before they become serious problems.

**Intervention**
- Intervention, including investigation and resolution of problems and complaints; and
- Negotiation and professional guidance to help residents resolve conflicts or problems experienced in the long-term care facility with staff, family members or others.

**Advocacy**
- Representing the interests of residents before governmental agencies and seeking administrative, legal and other remedies, to protect the health, safety, welfare and rights of the residents; and
- Commenting on, facilitating public comment on, and recommending changes to existing or proposed laws, rules, regulations and other governmental policies and actions that affect the health, safety, welfare, and rights of residents.

**Office of The Long Term Care Ombudsman and the MDS 3.0 Section Q**
There are a number of ways the Office of the Long Term Care Ombudsman will be able to assist both residents and facility professionals alike concerning the Section Q process.
Ultimately, the Office of the Long Term Care Ombudsman’s focus is the resident, and his or her right to learn about community options. During the implementation of a Section Q referral, there are a number of issues that may arise where a resident would need, or ask for, the assistance of an advocate. A resident may want assistance and advocacy because of a difficult family issue. A resident may feel that he or she is not being listened to by their power of attorney, guardian, Local Contact Agency, or facility staff. A resident may want to transition into the community, but would like assistance and advocacy concerning developing a discharge plan that would meet the resident’s needs and desires. All of these issues are areas in which a Long Term Care Ombudsman could be of assistance.

However, there are many other issues that the Long Term Care Ombudsman may act upon in a more proactive way. Long Term Care Ombudsman may be involved in the education of family councils, facility professionals, and resident councils concerning the Section Q process. The Long Term Care Ombudsman may provide expert knowledge and consultation to facility professionals in regards to person-centered-planning, discharge planning, navigating difficult family situations, facilitating communication, and much more.

While the Office of the Long Term Care Ombudsman serves as an advocate for residents, the Long Term Care Ombudsmen are also available to assist and advise facility personnel. Long Term Care Ombudsmen do this through expert consultation, care plan meeting attendance, education, problem solving, person centered planning, and referrals.

The specific roles and responsibilities of The Office of The Long Term Care Ombudsman concerning the MDS 3.0 Section Q process are:

- **Provide educational sessions and materials to residents, family members and nursing home staff:** Deliver educational program to residents, resident councils, families, family councils, and interested facility staff outlining MDS Section Q and the transition referral process. Focus on the resident’s right to learn about living in the community and the processes that MDS Section Q triggers.

- **Assist in identifying candidates and residents:** While performing regular duties, identify residents who express an interest in learning about their community options. Also, identify potential candidates for specific transitioning programs, and refer as necessary.

- **Refer candidates to ServiceLink Resource Centers:** When a potential candidate or resident for the referral process has been identified, refer the resident to ServiceLink, and distribute ServiceLink brochure as appropriate.

- **Act on behalf, of and under direction of, the resident to attempt to resolve (to the resident’s satisfaction) any issues or complaints reported by the resident related to the referral and transition processes:** Working within the original scope of the Office of the Long Term Care Ombudsman (OLTCO), advocate for and assist residents with complaints related to both the referral process and the transitioning process. Complaints will be addressed and resolved to the resident’s satisfaction, per the policies and procedures of OLTCO.

- **Advocate for and support resident’s decision making process related to the transition referral process:** Assist and advocate for the resident during the transition process with issues related to the health, safety, welfare or rights of that resident. Ensure that the resident has a voice at all care plan meetings and community assessments. When guardian / power of attorney is present, work to make sure resident’s decisions and preferences are being taken into account concerning transitioning.
• Provide consultation to interested parties (residents, family members, facility staff, etc.) concerning resident’s rights, options, and the transfer referral process: Advise and confer with facility staff members concerning practices and issues related to referral process. Be an available resource for facilities, ServiceLink, residents, facility staff members and resident’s family members on residents’ rights with in the referral process and a resident’s right to learn about living in the community.

Helpful Tips from The Office of the Long Term Care Ombudsman:

• In many cases, a family member or loved one will act as a power of attorney or guardian when, in fact, they are neither. It is always helpful to ask for a copy of the power of attorney document or guardianship orders, and to make sure you know what authorities have been granted to the power of attorney or to the guardian.
• When a resident or elder has an activated power of attorney for healthcare, the resident or elder can still make decisions and express his or her preferences for their living situation.
• When a resident wants to return to the community, and the family members who would normally support the resident disagree, a difficult situation can arise. Calling the Office of the Long Term Care Ombudsman is helpful, as a Long Term Care Ombudsman can assist with problem solving, and will assist the resident by advocating for him or her.
• Even if an Ombudsman cannot help with a certain situation, they may be able to provide expert advice, refer to another agency that may be more helpful, or provide state or federal regulations concerning the issue.
• Keeping current state regulations and administrative rules on hand, including the current transfer and discharge and discharge planning regulations on hand will help you to be able to navigate issues and advocate for the resident’s wishes to be honored.
• While you do have to use the language that the MDS 3.0 presents (“Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”), you can create a conversation around question 0500, “Return to the Community”. You can try asking the resident what his or her goals are for the upcoming year, where he or she sees herself in the next few months, what his or her ideal situation would be like, and ask questions about his or her community supports. This will help the resident to understand question, and will create a more person-centered approach.
Section Q Case Studies and Answers
These cases are designed to promote discussion. Each individual’s situation is different and must be addressed individually. For MDS Conference; March 7 & 9, 2012

Case 1
Ms. K is an elderly woman who has been blind since birth. She lived with her parents growing up and then with her husband until he passed away. Terrified to live on her own, she moved into a nursing home about five years ago. She now uses a wheelchair 100% of the time.

On her annual MDS assessment, Ms. K. responded “Yes” to item Q0500B Return to Community. She is an active and very social person and said that she desperately wanted to leave the facility to live on her own.

Ms. K’s physician and the social worker at her nursing facility are very reluctant for her to leave the facility. They are very concerned about her safety while living alone, and for her being able to take care of her activities of daily living, because all of that was done for her in the facility.

Discussion Questions:

1. Who has the right to make this decision?
   Ms. K. There is no evidence of a legally authorized (court appointed) representative, and the physician or social worker has no legal standing to make this decision. They can offer their advice and share their concerns, but cannot interfere with this decision.

2. Does Ms. K have the right to take the risk of moving out of the nursing facility?
   Yes, Ms. K has the right to make her own medical decisions, including the right to accept or refuse medical services and settings.

3. What is the liability of the nursing facility after she is discharged?
   While the individual is a resident in the facility, the nursing facility is responsible for a thorough assessment of the individual resident’s needs, supporting the resident in achieving his or her highest level of functioning, discharge planning, implementation of the discharge plan. With the new Section Q, the facility should work closely with the community agency (local contact agency or service provider) that is providing transition planning and arranging community supports and services such as housing, transportation, personal care assistance, and other formal and informal supports. When there is a discharge plan developed that prepares the resident for discharge into the community there should be a smooth transition. There needs to be consideration given to meeting the resident's needs in the environment, availability of resources to provide care, treatment, etc. and educating the agency providing oversight of specific needs of the resident and how they are to be met. Resident protections concerning transfer and discharge are found at §483.12. A “post-discharge plan of care” means the discharge planning process, which includes, assessing continuing care needs and developing a plan designed to ensure the individual’s needs will be met after discharge from the facility into the community. After appropriate implementation of the nursing facility discharge plan, once the individual is smoothly discharged, the nursing facility is no longer responsible for the individual’s care. If the individual is Medicaid eligible, the community service providers and the State Medicaid Agency are responsible for assuring health and safety once the individual has transitioned back to the community.

4. What is the liability of the nursing facility if Ms. K responds Yes, and the assessor marks No?
   The nursing facility is required to make a referral to the LCA, and work with the LCA in a person centered approach to explore the individual’s options for supports and services in the community and the possibility that the individual may return to the community. The facility continues to be required to implement accurate discharge planning and follow-up under federal law and regulation 42 CFR 483.20 (i) (3).

5. If a competent individual resident determines that they want to talk to someone about returning to the community, does the nursing facility have the right to block the local contact agency from seeing the resident?
No. The U.S. Supreme Court decision in Olmstead vs. L.C. and the Americans with Disabilities Act require that residents have access to information and choices. Local contact agencies are designated by State Medicaid Agencies officials as part of a structured discharge planning process.

6. **How would you code Q0500B?**
   Code Q0500B = 1, Yes.

7. **What steps are then required?**
   A Yes response will trigger follow-up care planning, and discharge planning, and contacting the local contact agency according to your State’s protocols, usually within 10 business days.

8. **How would you code Q0600 Referral?**
   Code Q0600 = 2, Yes – referral made

9. **What steps are then required?**
   Begin appropriate care planning and discharge planning, and once the LCA talks with the resident and facility, if it is determined that there are supports and services that would enable the resident to return to the community, work with the LCA and/or designated agency on other follow-up measures.

P.S.: Ms. K did return to the community and has been living in an apartment on her own for over a year, with assistive technology equipment, a Personal Emergency Response System, home help, durable medical equipment, and a visiting nurse to set up her pill organizer.

Case 2
Ms. V is an elderly woman with mild dementia. She had previously been in a behavioral unit of a psychiatric hospital. She was hospitalized in an acute care hospital after a series of falls caused by a urinary tract infection which exacerbated her dementia. She was then discharged to a nursing facility for rehabilitation. Ms. V. says she has recovered from her illness and is interested in returning to community living.

Ms. V’s daughter lives 50 miles away and visits her mother monthly. The daughter had previously told the facility social worker that she was opposed to her mother leaving the facility to live in the community. She is concerned about her mother’s safety because of her previous wandering and multiple falls.

**Discussion Questions:**

**How would you approach and analyze item Q0100 – Participation in Assessment**

1. **Is the individual able to understand and participate in the assessment process?**

   Except in unusual circumstances, such as if the individual resident is unable to respond or understand or participate in the assessment proceedings, continue the assessment interview and code the responses accordingly.

   a. **How would you code Q0100?**
      Code Q0100A = 1, Yes, resident participated in assessment, and if the daughter participated in the assessment, Code Q0100 B = 1, Yes, family participated in assessment.

   b. **How would you code Q0500B?**
      When Ms. V. responded Yes to item Q0500B, Code Q500B = 1, Yes.

      Note: Review the previously recorded response to item Q0490 – Resident’s Preference to Avoid Being Asked Question Q0500B in the resident’s clinical record (or prior MDS assessment). Use this information in determining whether item Q0500B should be asked.
c. **How would you code Q0600?**
   Code Q0600 – Referral = 2, referral (of resident) made.

2. **Is the daughter a legally appointed guardian or legally authorized representative?** (Such a representative would be responsible for making decisions for the resident, including giving and withholding consent for medical treatment.)

No, there was nothing in the case description to indicate she is the legal guardian.

For discussion purposes, let’s assume Yes, she is the legally appointed guardian.

Continue the interview with the resident and record the individual’s responses in the client’s clinical record. Contact the legal guardian to interview them and obtain responses for the MDS assessment and record those on the MDS.

   a. **How would you code Q0100?**
      Code Q0100C = 1, Yes.
   
   b. **How would you code Q0500B?**
      If the daughter/guardian responds No to item Q0500B, Code Q500B = 0, No.
   
   c. **How would you code Q0600?**
      Code Q0600 – Referral = 0, No, referral (of resident) not needed.

Even though the daughter answered No to Q0500B, you may want to refer her to the local contact agency to obtain more information about the community living services and supports that are available for Ms. V. This will help her become fully informed about what their options are. This individual may or may not be able to successfully live in a less restrictive environment such as adult foster care or assisted living. The scope and intensity of supports and services (both formal and informal) that are available (or not) will be a major factor.

3. **If there is a court appointed guardian, is it necessary to obtain permission from the guardian before interviewing the resident?**
   No. If the resident has a court appointed guardian, the resident should still be asked the question (Q0500B) unless state law prohibits asking the resident. If the resident is unable to respond and participate in the assessment, then ask the family, significant other, or legal guardian. A guardian, family member or legally authorized person should not be consulted to the exclusion of the individual resident.

P.S.: Ms. V has been living alone in an independent living apartment for over a year, with twice-a-day personal care/homemakers for preparing breakfast and dinner and medication reminding, home delivered lunches, nightly safety checks by a neighbor, and weekly visits by her daughter. She is linked to the local Wanderguard program and she is able to use her Personal Emergency Response System if needed. The frequent service provider contacts provide a way to report changes in her condition readily and have helped result in her stable condition over the year.
Case 3
Ms. A is a recovering alcoholic with numerous mental health issues/behaviors. She is age 63 with no Medicare coverage. She has income from mineral rights royalties, her deceased husband's pension and her social security. She receives too much to qualify for Medicaid, but not enough to pay for private pay nursing home care. Ms. A did not want to apply for a Miller's Trust nor disability. A nursing facility took her in for what she could afford to pay, but after residing for one year at a nursing facility, she said she wanted to return to live in the community in her home town which is about 67 miles away.

Discussion Questions:
1. How would you approach and analyze item Q0100 – Participation in Assessment
   Is the individual able to understand and participate in the assessment process?
   If so, continue the assessment interview and code the responses accordingly.

   a. How would you code Q0100?
   Code Q0100A = 1, Yes, resident participated in assessment.

2. How would you code Q0500B?
   Code Q500B = 1, Yes. Follow up care planning and discharge planning shall be initiated.

3. How would you code Q0600?
   Code Q0600 – Referral = 1, Yes, referral made.

4. Then what are your next steps?
   Initiate discharge planning and implementation of the discharge plan. Refer Ms. A to the local contact agency to obtain more information about the community living services and supports that are available. This will help make her fully informed about what her options are. The availability of services and supports, both formal and informal, will be a major factor in her choice and ability to make a sustained move to community living.

3. What types of (non-Medicaid) services and supports do you think Ms. A may need to transition and sustain community living? What would you recommend to the local contact agency?
   Ms. A needs supportive housing, such as senior apartment living. Their staff that can provide her help when needed, ongoing service coordination and assistance in fully engaging in community living (e.g. access to social groups, substance abuse prevention, etc.) She also needs ongoing monitoring to assure medication administration as well as ongoing follow-up with her local mental health clinic. Some non-Medicaid supports are available to Ms. A through programs managed by her local Area Agency on Aging and funded in part through Older Americans Act funds.

P.S.: Ms. A was referred to the designated local contact agency by the nursing facility. The local contact agency in their region is an Aging and Disability Resource Center (ADRC). The ADRC is responsible for providing information and assistance (referral) and options counseling about long term services and supports available in the community to older persons and adults with disabilities. –“Options Counseling is a person-centered, interactive, decision-support process whereby individuals are supported in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. The process may include developing action steps toward a goal or a LTSS plan, and, when requested, assistance in accessing support options. It also includes following-up with the individual. Options Counseling is available to all persons regardless of their income or financial assets.”

Through the ADRC, Ms. A was connected to local non-Medicaid resources to supplement services covered by her own income. The ADRC worked with the State’s relocation specialist to locate senior housing. The nursing facility, ADRC, and ombudsmen worked together to arrange home delivered meals and public transportation and to connect Ms. A. to ongoing mental health services to support sustained community living.
### Appendix 2
MINIMUM DATA SET (MDS) 3.0

#### Section Q Participation in Assessment and Goal Setting

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q0100. Participation in Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
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</tr>
<tr>
<td>A.</td>
<td>Resident participated in assessment</td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Family or significant other participated in assessment</td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. No family or significant other available</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Guardian or legally authorized representative participated in assessment</td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. No guardian or legally authorized representative available</td>
<td></td>
</tr>
</tbody>
</table>

| **Q0300. Resident's Overall Expectation** | Complete only if A0310E = 1 |
| Enter Code | |
| A. | Select one for resident's overall goal established during assessment process. |
| 1. Expects to be discharged to the community | |
| 2. Expects to remain in this facility | |
| 3. Expects to be discharged to another facility/institution | |
| 9. Unknown or uncertain | |
| B. | Indicate information source for Q0300A |
| 1. Resident | |
| 2. If not resident, then family or significant other | |
| 3. If not resident, family or significant other, then guardian or legally authorized representative | |

| **Q0400. Discharge Plan** | |
| Enter Code | |
| A. | Is active discharge planning already occurring for the resident to return to the community? |
| 0. No | |
| 1. Yes | Skip to Q0600, Referral |

| **Q0500. Return to Community** | |
| Enter Code | |
| A. | Ask the resident (or family or significant other if resident is unable to respond): “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?” |
| 0. No | |
| 1. Yes | |
| 2. Unknown or uncertain | |

| **Q0550. Resident’s Preference to Avoid Being Asked Question Q0500A again** | |
| Enter Code | |
| A. | Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked again every quarter about returning to the community? |
| 0. No |--then document in resident's chart and do not ask again on future quarterly assessments. |
| 1. Yes | |
| 2. Information not available | |
| B. | Indicate information source for Q0550A |
| 1. Resident | |
| 2. If not resident, then family or significant other | |
| 3. If not resident, family or significant other, then guardian or legally authorized representative | |

| **Q0600. Referral** | |
| Enter Code | |
| Has a referral been made to the Local Contact Agency? |
| 0. No | referral not needed |
| 1. No | referral is or may be needed (For more information See Section Q Care Area Assessment #20) |
| 2. Yes | referral made |
SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident’s overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i) (3)). Section Q of the MDS uses a person-centered approach to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q0100: Participation in Assessment

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<thead>
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<th>Code</th>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>Guardian or legally authorized representative participated in assessment</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Item Rationale

Health-related Quality of Life

- Residents who actively participate in the assessment process and in developing their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.15 Quality of Life).
Q0100: Participation in Assessment (cont.)

- During the care planning meetings, the resident should be made comfortable and verbal communication should be directly with him or her.

- Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they be involved in the assessment process.

- If the individual resident is unable to understand the process, his or her family member, significant other, and/or guardian/legally authorized representative, who represents the individual, should be invited to attend the assessment process whenever possible.

- When the resident is unable to participate in the assessment process, family members, significant others, and/or guardian/legally authorized representatives can provide information about the resident’s needs, goals, and priorities.

Steps for Assessment

1. Review the medical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.

2. Ask the resident, the family member or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if he or she actively participated in the assessment process.

3. Ask staff members who completed the assessment whether or not the resident, family or significant other, or guardian or legally authorized representative participated in the assessment process.

Coding Instructions for Q0100A, Resident Participated in Assessment

Record the participation of the resident in the assessment process.

- **Code 0, no:** if the resident did not actively participate in the assessment process.

- **Code 1, yes:** if the resident actively and meaningfully participated in the assessment process.

Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

Record the participation of the family or significant other in the assessment process.

- **Code 0, no:** if the family or significant other did not participate in the assessment process.

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**DEFINITIONS**

**FAMILY OR SIGNIFICANT OTHER**
A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not, however, include staff at the nursing home.

**GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE**
A person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.
Q0100: Participation in Assessment (cont.)

- **Code 1, yes**: if the family or significant other(s) did participate in the assessment process.
- **Code 9, no family or significant other available**: None of the above—resident has no family or significant other.

**Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment**

_Record the participation of the guardian or legally authorized representative in the assessment process._

- **Code 0, no**: if guardian or legally authorized representative did not participate in the assessment process.
- **Code 1, yes**: if guardian or legally authorized representative did participate in the assessment process.
- **Code 9, no guardian or legally authorized representative available**: None of the above—resident has no guardian or legally authorized representative.

**Coding Tips**

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident’s perspective if he or she is able to express it.
- Significant other does not include nursing home staff.
- No family or significant other available means the individual resident has no family or significant other, not that they were not consulted.

Q0300: Resident’s Overall Expectation

_Complete only when A0310E=1. (First assessment on admission/entry or reentry.)_
Q0300: Resident’s Overall Expectation (cont.)

Item Rationale

This item identifies the resident’s general expectations and goals for nursing home stay. The resident should be asked about his or her own expectations regarding return to the community and goals for care. The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet long-term care needs. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.

Some residents have very clear and directed expectations that will change little prior to discharge. Other residents may be unsure or may be experiencing an evolution in their thinking as their clinical condition changes or stabilizes.

Health-related Quality of Life

• Unless the resident’s goals for care are understood, his or her needs, goals, and priorities are not likely to be met.

Planning for Care

• The resident’s goals should be the basis for care planning.

Steps for Assessment

1. Ask the resident about his or her overall expectations to be sure that he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices.
2. Ask the resident to consider his or her current health status, expectations regarding improvement or worsening, social supports, and opportunities to obtain services and supports in the community.
3. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.
4. The resident’s stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative may also be recorded in the clinical record.
5. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some residents may be unable to provide a clear response. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.
Q0300: Resident’s Overall Expectation (cont.)

6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected must reflect the resident’s perspective if he or she is able to express it.

7. In some guardianship situations, the decision-making authority regarding the individual’s care is vested in the guardian. But this should not create a presumption that the resident is not able to comprehend and communicate their wishes.

Coding Instructions for Q0300A, Resident’s Overall Goals Established during Assessment Process

Record the resident’s expectations as expressed by her or him. It is important to document their expectations.

- **Code 1, expects to be discharged to the community**: if the resident indicates an expectation to return home, to assisted living, or to another community setting.
- **Code 2, expects to remain in this facility**: if the resident indicates that he or she expects to remain in the nursing home.
- **Code 3, expects to be discharged to another facility/institution**: if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- **Code 9, unknown or uncertain**: if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative do not exist or are not available to participate in the discussion.

Coding Tips

- This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident’s expectations; not whether or not the staff considers them to be realistic or not.
- Q0300A, Code 1 “expects to be discharged to the community” may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid residents with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1).
- Avoid trying to guess what the resident might identify as a goal or to judge the resident’s goal. Do not infer a response based on a specific advance directive, e.g., “do not resuscitate” (DNR).
- The resident should be provided options, as well as, access to information that allows him or her to make the decision and to be supported in directing his or her care planning.
Q0300: Resident’s Overall Expectation (cont.)

- If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. Families, significant others or legal guardians should be consulted as part of the assessment.

**Coding Instructions for Q0300B, Indicate Information Source for Q0300A**

- **Code 1, resident**: if the resident is the source for completing this item.
- **Code 2, if not resident, then family or significant other**: if the resident is unable to respond and a family member or significant other is the source for completing this item.
- **Code 3, if not resident, family or significant other, then guardian or legally authorized representative**: if the guardian or legally authorized representative is the source for completing this item because the resident is unable to respond and a family member or significant other is not available to respond.
- **Code 9, unknown or uncertain (none of the above)**: if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0300A = 9).

**Examples**

1. Mrs. F. is a 55-year-old married woman who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. She was admitted to the nursing home 1 week ago for rehabilitation, specifically for transfer, gait training, and wheelchair mobility training. Mrs. F. is extremely motivated to return home. Her husband is supportive and has been busy adapting their home to promote her independence. Her goal is to return home once she has completed rehabilitation.

   **Coding:** Q0300A would be **coded 1, expects to be discharged to the community.**
   Q0300B would be **coded 1, resident.**
   **Rationale:** Mrs. F. has clear expectations and a goal to return home.

2. Mr. W. is a 73-year-old man who has severe heart failure and renal dysfunction. He also has a new diagnosis of metastatic colorectal cancer and was readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. He relies on nursing staff for all activities of daily living (ADLs). He indicates that he is “strongly optimistic” about his future and only wants to think “positive thoughts” about what is going to happen and needs to believe that he will return home.

   **Coding:** Q0300A would be **coded 1, expects to be discharged to the community.**
   Q0300B would be **coded 1, resident.**
Q0300: Resident’s Overall Expectation (cont.)

Rationale: Mr. W has a clear goal to return home. Even if the staff believe this is unlikely based on available social supports and past nursing home residence, this item should be coded based on the resident’s expressed goals.

3. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that “It’s such a nice day. Now let’s talk about it more.” When her daughter is asked about goals for her mother’s care, she states that “We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities, we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her.” The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days and that the family does not have the capacity to provide all the care the resident needs.

Coding: Q0300A would be coded 2, expects to remain in this facility.
Q0300B would be coded 2, family or significant other.

Rationale: Ms. T is not able to respond, but her daughter has clear expectations that her mother will remain in the nursing home where she will be made comfortable for her remaining days.

4. Mrs. G., an 84-year-old female with severe dementia, is admitted by her daughter for a 7-day period. Her daughter stated that she “just needs to have a break.” Her mother has been wandering at times and has little interactive capacity. The daughter is planning to take her mother back home at the end of the week.

Coding: Q0300A would be coded 1, expects to be discharged to the community.
Q0300B would be coded 2, family or significant other.

Rationale: Mrs. G. is not able to respond but her daughter has clear expectations that her mother will return home at the end of the 7-day respite visit.

5. Mrs. C. is a 72-year-old woman who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, she was diagnosed with moderate dementia and was unable to voice consistent preferences for her own care. She has no living relatives and no significant other who is willing to participate in her care decisions. The court appointed a legal guardian to oversee her care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in Mrs. C.’s best interest that she be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

Coding: Q0300A would be coded 3, expects to be discharged to another facility/institution.
Q0300B would be coded 3, guardian or legally authorized representative.
Q0300: Resident’s Overall Expectation (cont.)

**Rationale:** Mrs. C. is not able to respond and has no family or significant other available to participate in her care decisions. A court-appointed legal guardian determined that it is in Mrs. C.’s best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. Ms. K. is a 40-year-old with cerebral palsy and a learning disability. She lived in a group home 5 years ago, but after a hospitalization for pneumonia she was admitted to the nursing home for respiratory therapy. Although her group home bed is no longer available, she is now medically stable and there is no medical reason why she could not transition back to the community. Ms. K. states she wants to return to the group home. Her legal guardian agrees that she should return to the community to a small group home.

**Coding:** Q0300A would be **coded 1, expects to be discharged to the community (small group homes are considered to be community setting).**

Q0300B would be **coded 1, Resident.**

**Rationale:** Ms. K. understands and is able to respond and says she would like to go back to the group home. Her expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that Ms. K. is medically stable and would like to go back to the community, she confirmed that it is in Ms. K.’s best interest to be transferred to a group home. This information should also be recorded in the individual’s clinical record. (If Ms. K had not been able to communicate her choice and the guardian made the decision, Q0300B would have been coded 3.)

Q0400: Discharge Plan

**Item Rationale**

**Health-related Quality of Life**

- Returning home or to a non-institutional setting can be very important to a resident’s health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and supports that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without adequate discharge planning occurring (planning and implementation of a plan before discharge) could result in the resident’s decline and increase the chances for rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.
Q0400: Discharge Plan (cont.)

Planning for Care

• Many nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.

• Important progress has been made so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U. S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services and supports have a right to receive services in the least restrictive and most integrated setting.

• The care plan should include the name and contact information of a primary care provider chosen by the resident, family, significant other, guardian or legally authorized representative, arrangements for the durable medical equipment (if needed), formal and informal supports that will be available, the persons and provider(s) in the community who will meet the resident’s needs, and the place the resident is going to be living.

• Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. For example, a referral to the LCA may be appropriate for some individuals with Alzheimer’s disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.

• Discharge instructions should include at a minimum:
  — the individual’s preferences and needs for care and supports:
    o personal identification and contact information, including Advance Directives;
    o provider contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    o brief medical history;
    o current medications, treatments, therapies, and allergies;
    o arrangements for durable medical equipment;
    o arrangements for housing;
    o arrangements for transportation to follow-up appointments; and
    o contact information at the nursing home if a problem arises during discharge
  — A follow-up appointment with the designated primary care provider in the community and other specialists (as appropriate).
  — Medication education.
Q0400: Discharge Plan (cont.)

— Prevention and disease management education, focusing especially on warning symptoms for when to call the doctor.
— Who to call in case of an emergency or if symptoms of decline occur.
— Nursing facility procedures and discharge planning for subacute and rehabilitation community discharges are most often well defined and efficient.
— Section Q has broadened the scope of the traditional boundary of discharge planning for sub-acute residents to encompass long stay residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, transportation, employment if desired, and social engagement opportunities.
  o Asking the resident and family about whether they want to talk to someone about a return to the community gives the resident voice and respects his or her wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
  o The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with transition services planning. They should work closely together. The LCA is the entity that does the community support planning, (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, etc.) A referral to the LCA may come from the nursing facility by phone, by e-mails by a state’s on-line/website or by other state-approved processes. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process.
  o Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family, guardian, or significant others concerning a potential return to the community. A thorough review of medical, psychological, functional, and financial information is necessary in order to assess what each resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.
  o Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now more readily available. Resource availability and eligibility coverage varies across States and local communities.
  o Should a planned relocation not occur, it might create stress and disappointment for the resident and family that will require support and nursing home care planning interventions.

• Involve community mental health resources (as appropriate) to ensure that the resident has support and active coping skills that will help him or her to readjust to community living.
Q0400: Discharge Plan (cont.)

- Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge.
- For additional guidance, see CMS’ Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting. Available at [http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf)

Steps for Assessment

1. A review should be conducted of the care plan, the medical record, and clinician progress notes, including but not limited to nursing, physician, social services, and therapy to consider the resident’s discharge planning needs.

2. If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other or guardian, as designated by the individual.

3. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and the capability to address a resident’s needs and arrange for that resident to discharge back to the community, a referral to the LCA may not be necessary. Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them.

4. Record the resident’s expectations as expressed/communicated, whether you assess that they are realistic or not realistic.

5. If the resident’s discharge needs cannot be met by the nursing facility, an evaluation of the community living situation to evaluate whether it can meet the resident’s needs should be conducted by the LCA, along with other community providers who will be providing the transition and other community based services to determine the need for assistive/adaptive devices, medical supplies, and equipment and other services.

6. The resident, his or her interdisciplinary team, and LCA (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance).

7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes, etc.).

8. A determination of family involvement, capability, and support after discharge should also be made.
Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400A, Is Active Discharge planning already occurring for the Resident to Return to the Community?

• **Code 0, no:** if there is not active discharge planning already occurring for the resident to return to the community.

• **Code 1, yes:** if there is active discharge planning already occurring for the resident to return to the community; skip to **Referral** item (Q0600).

Q0490: Resident’s Preference to Avoid Being Asked Question Q0500B

*For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, 99)*

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<th>Enter Code</th>
<th>Does the resident’s clinical record document a request that this question be asked only on comprehensive assessments?</th>
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</thead>
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<tr>
<td>0. No</td>
<td>1. Yes → Skip to Q0600, Referral</td>
</tr>
<tr>
<td></td>
<td>8. Information not available</td>
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**Item Rationale**

This item directs a check of the resident’s clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next annual assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, Referral.

Note: Let the resident know that they can change their mind at any time and should be referred to the LCA if they voice their request, regardless of schedule of MDS assessment(s).

If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B.

Coding Instructions for Q0490, Does the resident’s clinical record document a request that this question be asked only on comprehensive assessments?

• **Code 0, no:** if there is no notation in the resident’s clinical record that he or she does not want to be asked Question Q0500B again.
Q0490: Resident’s Preference to Avoid Being Asked Question
Q0500B (cont)

- **Code 1, yes**: if there is a notation in the resident’s clinical record to not ask Question Q0500B again, except on comprehensive assessments.

Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, Referral.
If this is a comprehensive assessment, proceed to the next item Q0500B.

- **Code 8, Information not available**: if there is no information available in the resident’s clinical record or prior MDS 3.0 assessment.

**Coding Tips**

- Carefully review the resident’s clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded No to item Q0550. If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item Q0550A.

**Examples**

1. Ms. G is a 45-year-old woman, 300 pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen at all times. Ms. G also requires 2 person assistance with bathing and transfers to the commode. She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities.

   **Coding**: Q0490 would be **coded 1, Yes, skip to Q0600; because this is a quarterly assessment.**

   If this is a comprehensive assessment, then proceed to the next item Q0500B.

   **Rationale**: On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to community living (No on Q0550A).

2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer’s disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

   **Coding**: Q0490 would be **coded 1, Yes, skip to Q0600; Unless this is a comprehensive assessment, then proceed to the next item Q0500B.**

   **Rationale**: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.
Q0500: Return to Community

For Admission, Quarterly, and Annual Assessments.

Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident’s expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term services and supports in the least restrictive setting. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations.

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to the resident’s health and quality of life.
- This item identifies the resident’s desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in Olmstead v. L.C., residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.
- Item Q0500B requires that the resident be asked the question directly and formalizes the opportunity for the resident to be informed of and consider his or her options to return to community living. This ensures that the resident’s desire to learn about the possibility of returning to the community will be obtained and appropriate follow-up measures will be taken.
- The goal is to obtain the informed choice and preferences expressed by the resident and to provide information about available community supports and services.

Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.
Q0500: Return to Community (cont.)

Steps for Assessment: Interview Instructions

1. At the initial admission assessment and in subsequent follow-up assessments (as applicable), make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents.

2. Ask the resident if he or she would like to speak with someone about the possibility of returning to live in the community. Inform the resident that answering yes to this item signals the resident’s request for more information and will initiate a contact by someone with more information about supports available for living in the community. A successful transition will depend on the resident’s preferences and choices and the services, settings, and sometimes family supports that are available. In many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Answering yes does not commit the resident to leave the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community. Answering no is also not a permanent commitment. Also inform the resident that he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at any time.

3. Explain that this item is meant to provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care. A viable and workable discharge plan requires that the nursing home social worker or staff talk with the resident before making a referral to a local contact agency to explore topics such as: what returning to the community means, i.e., a variety of settings based on preferences and needs; the arrangements and planning that the NF/SNF can make; and obtaining family or legal guardian input. This step will help the resident clarify their discharge goals and identify important information for the LCA or, in some instances may indicate that the resident does not want to be referred to the LCA at this time. Also explain that the resident can change his/her mind at any time.

4. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can then be obtained from family or a significant other, as designated by the individual. If family or significant others are not available, a guardian or legally authorized representative, if one exists, can provide the information.

5. Ask the resident if he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her family, significant other, or guardian or legally authorized representative—to obtain additional information about services and supports that would be available to support community living.

Coding Instructions for Q0500B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”
Q0500: Return to Community (cont.)

- **Code 0, no:** if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to the community.

- **Code 1, yes:** if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to the community.

- **Code 9, unknown or uncertain:** if the resident cannot understand or respond and the family or significant other is not available to respond on the resident’s behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

**Coding Tips**

- A “yes” response to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency about the resident’s request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local agency for follow-up as the resident desires.

- Follow-up is expected in a “reasonable” amount of time and 10 business days is a recommendation and not a requirement. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident’s needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face to face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options.

- Some residents will have a very clear expectation and some may change their expectations over time. Residents may also be unsure or unaware of the opportunities available to them for community living with services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a critical step. It is important to clarify the resident’s discharge needs and expectations, determine what the SNF/NF usually provides and can arrange, and obtain information about transition barriers or challenges based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24-hour care issues, etc.

- The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF can talk with the LCA to see what is available that does not require family support.

- Current return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other, guardian, and/or legally appointed decision-maker for that individual could be asked the question.
Q0500: Return to Community (cont.)

Examples

1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, “I’m afraid I can’t” to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he would like more information on community supports.

   **Coding:** Q0500B would be **coded 1, yes**.
   **Rationale:** Coding Q0500B as yes should trigger a visit by the nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local agency within approximately 10 business days.

2. Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in the Hope Nursing Home for the past 20 years. She once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, Ms. C. was sent to the nursing home because she now required regular chest physical therapy and was told that she could no longer live in her previous group home because her needs were more intensive. No one had asked her about returning to the community until now. When administered the MDS assessment, she responded yes to item Q0500B.

   **Coding:** Q0500B would be **coded 1, yes**.
   **Rationale:** Ms. C.’s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living.

3. Mr. D. is a 65-year-old man with a severe heart condition and interstitial pulmonary fibrosis. At the last quarterly assessment, Mr. D. had been asked about returning to the community and his response was no. He also responds no to item Q0500B. The assessor should ask why he responded no. Depending on the response, follow-up questions could include, “Is it that you think you cannot get the care you need in the community? Do you have a home to return to? Do you have any family or friends to assist you in any way?” Mr. D. responds no to the follow-up questions and does not want to offer any more information or talk about it.

   **Coding:** Q0500B would be **coded 0, no**.
   **Rationale:** During this assessment, he was asked about returning to the community and he responded no.
Q0550: Resident’s Preference to Avoid Being Asked Question Q0500B again

Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments (rather than being asked yearly only on comprehensive assessments)?

- **Code 0, no:** if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident’s clinical record and ask question Q0500B again only on the next comprehensive assessment.

- **Code 1, yes:** if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments.

- **Code 9, information not available:** if the resident cannot respond and the family or significant other is not available to respond on the resident’s behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.
Q0550: Resident’s Preference to Avoid Being Asked Question
Q0500B again (cont.)

Coding Instructions for Q0550B, Indicate information source for Q0550A

- **Code 1, Resident**: if resident responded to Q0550A.
- **Code 2, If not resident, then family or significant other**.
- **Code 3, If not resident, family or significant other, then guardian or legally authorized representative**.
- **Code 8, No information source available**: if the resident cannot respond and the family or significant other is not available to respond on the resident’s behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Example

1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her and she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care.

   **Coding**: Q0550A would be **coded 1, Yes**.
   
   Q0550B would be **coded 1**.

   **Rationale**: Ms. W. needs longer term restorative nursing care to recover from her falls before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.

Q0600: Referral

Item Rationale

**Health-related Quality of Life**

- Returning home or to a non-institutional setting can be very important to the resident’s health and quality of life.
Q0600: Referral (cont.)

Planning for Care

• Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Steps for Assessment: Interview Instructions

1. If Item Q0400A is coded 1, yes, then complete this item.
2. If Item Q0490B is coded 1, yes, then complete this item.
3. If Item Q0500B is coded 1, yes, then complete this item.

Coding Instructions

• **Code 0, no: Referral not needed;** determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident’s discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Or, if resident or family, etc., responded no to Q0500B.

• **Code 1, no: Referral is or may be needed;** determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) that the designated local contact agency needs to be contacted but the referral has not been initiated at this time. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.

• **Code 2, yes: Referral made;** if referral was made to the local contact agency. For example, the resident responded yes to Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.

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**DEFINITIONS**

**DESIGNATED LOCAL CONTACT AGENCY**

Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging/Disabled Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities. See Appendix C for listings.

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Local Contact Agency (LCA) Point of Contact List

Q0600: Referral (cont.)

Coding Tips

- State Medicaid Agencies have designated Local Contact Agencies and a State point of contact (POC) to coordinate efforts to implement Section Q designate LCAs for their State’s skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate.

- Several resources are available at the Return to Community web site at: http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage.
  — The State-by-State list of Local Contact Agencies and POC Section Q Coordinator Information.
  — MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.
  — The Section Q Pilot Test Results report describes the results of user testing of the new items in Section Q.

- Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some resident’s return to their community. The nursing home and local agency staff members should guard against raising the resident and their family members’ expectations of what can occur until more information is obtained.

- Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident’s medical needs, finances and available community transition resources.

- The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible.

- The local contact agency team must explore community care options/supports and conduct appropriate care planning to determine if transitions back to the community is possible.

- Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident’s medical condition, insufficient financial resources, problems with caregiving supports, community resource gaps, etc., preventing discharge to the community.

- When Q0600 is answered 1, No, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community.
Q0600: Referral (cont.)

Examples

1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was “Yes” to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son’s school and use accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops and appliances.

   **Coding:** Q0500B would be coded **1, yes**.
   Q0600 would be coded **2, yes**.

   **Rationale:** The social worker or discharge planner would make a referral to the designated local contact agency for their area and Q0600 would be coded as 2, yes.

2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns because of falls and difficulties cooking and proper nutrition. She said yes to Q0500B. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed for Ms. V.

   **Coding:** Q0600 would be coded **1, no**.

   **Rationale:** Ms. V indicated that she wanted to have an opportunity to talk to someone about return to community. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. Q0600 would be coded as no- “referral is or may be needed.” The Care Area Assessment #20 is triggered and it will be used to guide the follow-up process. Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated local contact agency.
MDS 3.0 Section Q Implementation
Questions and Answers
(Q & As from July 6, 2011 to June 30, 2012)

ASKING THE SECTION Q QUESTIONS

1. What are the main Section Q April 2012 changes to the MDS 3.0 form and manual? Why were these changes made?

Response:
The main changes to the Section Q form were:

- **Eliminated** the feasibility of discharge item Q0400B—What determination was made by the resident and care planning team that discharge to the community is feasible?.
- **Eliminated** Item 0500A—Has the resident been previously asked about returning to the community?
- **Added** item Q0490: Resident’s Preference to Avoid Being Asked Question Q0500B directs the assessor to check the resident’s clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next annual assessment.
- **Added** item Q0550B that individuals can opt-out of being asked if they want to talk to someone about returning to the community on all but annual assessments (Q0550. Resident’s Preference to Avoid Being Asked Question Q0500B again).

In conjunction with Item Q0550, assessors must review the resident’s clinical record to determine if the clinical record documents a request that Item Q0500B be asked only on comprehensive assessments. This supports compliance with the resident’s preference.

- **Changed** Item Q0600. Referral to No – referral is or may be needed, to allow the nursing facility team to continue their discharge planning and preparation efforts, without making an immediate referral to the local contact agency. This response triggers the Care Area Assessment #20 process.

Some clarifying language changes were also made on the form and in the RAI User’s Manual (new language is bolded):

- The responses to Item Q0100 were clarified in the Manual to say that the Resident has no family or guardian.
- Item Q0400 asks, **Is active discharge planning already occurring …?** rather than asking about documentation.
- In Item Q0500B, language was added, “Do you want to talk to someone about the
possibility of **leaving this facility and returning to live and receive services in the community?**” to clarify the intent of the question.

-Clarifies that the nursing facility is responsible for making referrals to the Local Contact Agency under the State-established process. If the nursing facility through its discharge planning and referral process has the capability to completely address an individual resident’s needs, (i.e., home health services, durable medical equipment, medical services, etc.) and arranges for that resident to discharge back to the community, a referral to the Local Contact Agency may not be necessary.

-Clarifies that the individual resident should be actively involved in the assessment process—except in unusual circumstances, if the individual is unable to understand the process or unable to participate.

The CMS conducted an open dialog as part of the implementation of the MDS 3.0. There were Open Forum teleconferences with providers, monthly Medicaid agency teleconferences, discussion sessions at conferences, questions and answers were posted on the CMS website, pilot test results were posted, and ongoing input was received from the Improving Transitions Work Group (States and other stakeholders). As a result of this input, many program operation issues were resolved. Several suggestions for improving the functioning of Section Q were made:

- The existing skip patterns may preclude resident choice;
- The feasibility of discharge question may exclude potential candidates for transitioning;
- Some residents/families were upset by being asked about returning to the community;
- Need to better accommodate residents with cognitive impairments, dementia and mental illness; and
- Some residents needed more time to explore options.

The suggested changes were pilot tested in six States and the results were incorporated in the April 1, 2012 changes to the MDS 3.0. The intent of the changes adopts a more person-centered approach, placing the resident/family at the center of decision-making, giving individuals a voice and a choice while being sensitive to those who may be upset by the assessment process.

2. Is item **Q0100 – Participation in Assessment** related only to Section Q or is it related to the whole assessment?

**Response:**

Item **Q0100 – Participation in Assessment applies to the entire MDS 3.0 assessment.** It
reflects whether the resident actively engages in interviews and conversations as necessary to meaningfully contribute to the completion of the MDS 3.0. It should also include others, as appropriate, identified in item Q0100B – Family or Significant other participated in the assessment and/or item Q0100C – Guardian or legally authorized representative participated in the assessment.

3. What is the provider staff to do if a family member directs staff to not ask question Q0500B - Return to Community? How is this facility supposed to get Section Q questions answered?

**Background:** “We have an irate family member, who is also the legal representative, who is in another state and doesn’t want her relative in the nursing home asked any of the interview questions related to Section Q. Since she is out of state and not available to visit, and the resident is somewhat confused, she doesn’t want them upsetting the resident because she says there is nowhere else for her and there is no other family to care for her. There is nothing in the manual that I can see to tell the provider how to handle coding Section Q and dealing with the family that is not available.”

**Response:**
MDS 3.0 information including Section Q information is captured based on the resident’s current status. Although the family member is an important resource, the resident is the primary informant. Section Q items and instructions give an assessor certain latitude to use their judgment in situations such as this. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Other individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community, which could be a reason for the resident, family guardian and facility determine that the resident should opt out of question Q0500B for this resident. April 2012 RAI Manual changes have added two new items that can address this family member’s concern if the facility assesses that it is appropriate that the resident not be asked Q0500B for quarterly assessments.

- **Q0490:** Resident’s Preference to Avoid Being Asked Question Q0500B. This item directs a check of the resident’s clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next annual assessment.

- **Item Q0550** allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, Referral.
All residents must be asked question QQ0500B on admission and annual assessments unless there is an active discharge plan in place. If the resident is competent and wants to answer Section Q questions, family members cannot direct the facility not to ask the resident QQ0500B or any other MDS 3.0 item. We recognize that this could be a difficult situation for all parties, and yet the impetus for MDS 3.0 Section Q changes including the QQ0500B return to community question is to provide residents the opportunity to make known their choices and preferences to get information about available community supports and services. Another impetus was to meet the requirements of the Americans with Disabilities Act and the Olmstead vs. LC Supreme Court ruling of 1999 “to provide community based services for person with a disability” and to administer programs in the “most integrated setting appropriate to the needs of qualified individuals with disabilities.” An additional issue supporting changes in Section Q is that States are trying to rebalance long-term care spending by facilitating greater use of community services. While we understand your point that many residents cannot return to the community and asking them is upsetting, our experience is that the Money Follows the Person (MFP) and home and community-based services (HCBS) waiver programs in many States have successfully been able to transition residents to community living that nursing home staff did not believe could be transitioned. If the facility cannot resolve the issue with the family member, a State’s long-term care ombudsman is a resource to assist nursing home residents by resolving complaints related to the transitions process, as well as by providing information and education to consumers and their families, facility staff, and the general public regarding the transitions process.

IMPLEMENTATION RESOURCES

4. Where are Section Q materials, such as the local contact agency point of contact list (LCA POC), the Section Q questions and answers, the June 2010 Section Q Pilot report located on the CMS website?

Response:
The Section Q Return to Community Website is now located at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html. Section Q downloadable zip files can be selected at the bottom of web page under “presentations from the MDS 3.0 Section Q Training held on March 7 and March 9 2012;” “the conference agenda and handouts from the MDS 3.0 Section Q Training held on March 7 and March 9, 2012;” or “reports, point of contact charts, and reference materials designed to assist with Section Q implementation.”

5. Is there additional additional guidance available regarding the accountability/requirements of the State to ensure that MDS 3.0 Q referrals to a Local Contact Agency (LCA) are appropriately followed up on?

Response:
The CMS recognizes that each State must develop its Section Q and LCA referral processes
and monitoring based on its unique demographic and geographic characteristics, State units on aging, and infrastructure and funding mechanisms. The CMS’ general guidance is that States should monitor whether nursing homes are making LCA referrals and whether LCAs are making contact with residents referred in a timely manner (approximately 10 business days). If problems are identified, the State would analyze the cause of the problems and take necessary actions.

6. What expectations does CMS have regarding referrals for individuals who may be unable to transition due to lack of funds or lack of available services?

Response:
CMS understands that building partnerships, allocating resources, and addressing service delivery gaps takes time. CMS is working with States regarding several significant challenge areas nationally, including identifying affordable housing in urban or rural areas through its partnerships with Housing and Urban Development (HUD), finding community resources for the homeless and individuals with mental illness, supporting efforts that strengthen in-home supports and home modifications, expanding Aging and Disability Resource Center (ADRC) “no wrong door” approaches for private pay residents, etc. CMS is funding MFP planning and resource grants in most States to facilitate partnerships and build infrastructures, partnering with the Administration on Community Living (ACL) (formerly the Administration on Aging, the Office on Disability, and the Administration on Developmental Disabilities) to provide ADRC funding and resources, and coordinating with ACL and the Veterans Administration to utilize Veterans Directed Home and Community-Based Services (VD-HCBS). CMS suggests that States may want to contact their MFP Project Officer for specific guidance when challenges or problems are encountered.

7. We have residents who have Medicare, Medicaid, and VA benefits and it is sometimes confusing for us to figure out which pays for what at certain times. Does the VA provide descriptions of eligibility and contacts?

Response:
The VA provides answers to frequently asked questions at http://www.va.gov/ by searching on “Find Answers.” We have inserted VA responses to address this question:

a. How do I find out if I am eligible for any medical or drug benefits?

VA Response: You are eligible to apply for VA health care if you are a veteran of active military service and were discharged or released from service under honorable conditions, provided that you meet minimum duty requirements.
To apply for health care benefits, you will need a copy of your discharge papers and will need to fill out a form called 1010EZ. The form can be downloaded from https://www.1010ez.med.va.gov/sec/vha/1010ez/ or you can call 1-877-222-VETS and ask to have one mailed to you.

b. Am I eligible for a nursing home?
   VA Response: Veterans requiring nursing home care for a service-connected condition, or a veteran rated 70% or more, have mandatory eligibility. All other veterans are eligible on a resource and space-available basis. The best source for determining what assistance is available for these VA services, is the Social Work department at the nearest VA facility. To find the nearest facility, visit the facility page at http://www2.va.gov/directory/guide/home.asp. By clicking on the state on the map that is displayed, you will get a list of every VA facility in that state along with facility information.

c. Do VA benefits cover nursing home care that is not provided in a VA facility?
   VA Response: No. VA can pay for care only in nursing homes that participate in its contract program. Nursing homes that do not participate in its contract program are not covered by VA. Veterans and their families should contact the nearest VA facility for information on Long Term Care (LTC). They may also obtain information on Health Benefits at 1-877-222-8387 or on the Internet at http://www.va.gov/elig.

d. Does VA offer any assisted living help?
   VA Response: All questions about assisted living arrangements should be addressed to the Social Work Department at your nearest VA medical facility. They can provide information about services or other assistance available through VA and/or your local community.

e. How/where do I apply for health care?
   VA Response: For all information pertaining to health and medical care, please go to http://www.va.gov/healthbenefits/ This website provides information about health care eligibility, covered services, eligibility and enrollment, income
thresholds, applying for care, Veterans Identification cards, income verification, getting care, copays and charges, updating your medical information, information for family members, resources and also has an enrollment calculator. Please check this website for a wealth of information regarding health care and services provided by VA to eligible veterans. You can also obtain enrollment assistance by calling the VA Enrollment Service Center, Monday through Friday between the hours of 8:00 AM and 8:00 PM (Eastern Time) at 1-877-222-VETS.

**LCA RESPONSIBILITIES**

8. If we have a resident who has been assessed by the LCA, had an open case, and then the case was closed and the resident remains at the facility, do we need to continue to refer to the LCA even though they have closed the case? Also, if the resident doesn't qualify for Medicaid, but wants to return to the community, why would a referral to the LCA be needed? Could we just document that the resident is arranging private duty services?

**Response:**
First, the nursing facility does not have to refer all of its planned discharges (those with an active discharge plan in place) to the LCA, especially if they have established referral networks to provide all required services. Most nursing homes already have established discharge referral networks for short stay and some private pay residents. Close collaboration between the nursing facility and the LCA could also be beneficial to evaluate the resident's medical needs, finances and available community transition resources. Enriched transition resources including housing, in-home caretaker services and meals, home modifications, etc. are now available and will grow over time. Resource availability and eligibility coverage varies across local communities and States and these may present barriers to allowing some residents to return to their community.

We want to clarify that the LCA supports both Medicaid and private pay nursing home residents. MFP and ADRC funding is available for outreach and education functions for all client types (i.e. non-Medicaid clients also). ADRC funding for information and assistance services, options counseling and brief case management services may be used for adults age 18 and over. Certain HCBS waiver program services such as case management or transition support services may also be devoted to support some local contact agency functions. Each State is different and you can contact your Section Q State Point of Contact listed at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html) for specific information on resources and services for your private pay residents.

**GUARDIAN/LEGAL REPRESENTATIVE**
9. How does guardianship apply to Section Q questions for family members or representatives with power of attorney, legally appointed guardian or legally authorized representative, etc.?

Response:
The individual resident should be actively involved in the assessment process in order to determine the resident’s expectations and perspective for care planning. Individual residents should be asked about inviting significant others or family members to participate, and if they desire their family to be involved in the assessment process. While family or legally authorized representatives may be involved, the response selected must reflect the resident’s perspective if he or she is able to express it.

Exceptions to this person-centered process are in the unusual circumstances when the individual is unable to understand the process or is unable to participate (respond). As the RAI User’s Manual states, “If the individual resident is unable to understand the process, his or her family member, significant other, or guardian, who represents the individual, should be invited to attend the assessment process whenever possible.”

If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative. A guardian is an individual appointed by the court to make decisions for the resident. This includes giving and withholding consent for medical treatment. A legally authorized representative is designated by the resident under State law to make decisions on individual’s behalf when they are not able to do so themselves. This includes a medical power of attorney.

10. What is the intent of item Q0500 - Return to Community? If a resident has advanced dementia (but can still respond to questions) and has a power of attorney making decisions on his or her behalf due to lacking capacity for decision making, does this question get asked to the resident or the power of attorney for health care?

Response:
If a resident can respond and understand the questions, the resident should be asked the questions. In addition, if a resident has a guardian the guardian should also be asked the questions and information should be provided to the guardian on community care options, services, and supports. Many guardians do not know what care options are available in the community. However, in a few States, a State law may prohibit asking this question of specific residents. The legal status of the resident-guardian relationship may need to be verified in your State.
If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative. A guardian is an individual appointed by the court to make decisions for the resident. This includes giving and withholding consent for medical treatment. A legally authorized representative is designated by the resident under State law to make decisions on individual’s behalf when they are not able to do so themselves. This includes a medical power of attorney. Facilities should encourage the involvement of family or significant others in the discussion. While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, if the resident is uncertain about his or her goals, the response selected must reflect the resident’s perspective if he or she is able to express it.

11. Can you please clarify how Section Q questions should be administered when the resident has a court appointed guardian?

**Background:** “This is a hot topic this week in Missouri. Section Q of the RAI manual speaks of resident voice and it is my understanding that the resident has the right to be asked item number Q0500B “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?” even if they have a guardian. Then, if they say yes, they have a right to be referred to gain additional education. Of course, the guardian has final say on where the resident lives and the LCA would not/could not transition without guardian permission. However, we are finding that some guardians do not want the resident asked the question in Q0500B and furthermore do not want the resident referred to the LCA.”

**Response:** The central question is this: if the resident has a court appointed guardian who opposes the resident being asked the question in Q0500B and opposes referral, should the resident be asked the question and referred against the guardian’s wishes? Each State has its own guardianship law and these will not change as a result of MDS 3.0. Section Q does not make a decision about leaving the facility and returning to a community based setting. Section Q simply asks the resident if they … “want to talk to someone about the possibility of returning to the community?”

A guardian/legally authorized representative is defined in the MDS 3.0 Resident Assessment Instrument (RAI) manual as a person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment. If the resident has a court appointed guardian, the resident should still be asked the question (Q0500B) unless State law prohibits asking the resident. If the resident is unable to respond, then ask the family, significant other, or legal guardian. A guardian, family member or legally authorized individual should not be consulted to the exclusion of the resident.
In some guardianship situations, the decision-making authority regarding the individual’s care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes. As part of your assessment research, the letters of guardianship should be checked, because the guardian’s powers may be limited and exclude the right to make healthcare decisions.

A referral to the local contact agency should be made if the resident wishes, even if they have a legal guardian, durable power of attorney for health care or a legally authorized representative, in accordance with State law.

Item Q0550 affords an opt-out provision for being asked question Q0500B. Return to Community. But the MDS 3.0 form and RAI User’s Manual clearly state that the resident should be asked the question, (or family or significant other of guardian, if resident is unable to respond). Individuals have rights to be asked about and voice their care preferences, unless specifically proscribed by law. The guardian may be authorized, under applicable law, to make medical care decisions on an individual’s behalf, including giving and withholding consent for medical treatment, when they are not able to do so themselves. Asking and responding to questions about obtaining information about options and choices is different from making medical decisions. State guardianship law should be consulted. Some State laws may stipulate that only the guardian may be consulted regarding questions involving medical treatment, but this is rare.
Nursing Facility Social Service Duties and Best Practices

Nursing home social workers provide many services to both residents and family members, working on behalf of the resident. In addition to many other duties, the social worker works closely with doctors and nursing staff to develop specific care plans based on the needs of the resident.

**Medicare/Medicaid Liaison**

A nursing home social worker acts as a liaison between the resident and Medicare and Medicaid. When a resident has no other health insurance benefits to pay for the nursing home stay, the social worker assists in gathering, preparing and submitting paperwork to the Medicare and Medicaid departments for approval. The social worker may also assist the resident or family in applying for other special programs, such as the Medicare drug plan and community waivers.

**Psychosocial Care**

A social worker provides psychosocial care for the nursing home residents and their families. Social workers first assess the residents' mental health and screen for depression before admittance and upon arrival to the nursing home. Throughout the resident's stay, the social worker provides counseling on a wide variety of issues, such as adjustment to the nursing home, as well as grief and loss.

**Discharge Planning**

Nursing Facility social workers perform discharge-planning duties for residents. Discharge-planning involves preparing resources for and speaking with the resident and his/her family about changes and coping strategies after discharge from the nursing facility. The social worker may arrange for home health nurse visits and follow-up care with doctors. The social worker also gives advice on adjusting to home life, especially if the resident has had an extended nursing facility stay.

**Resident Satisfaction**

Resident satisfaction plays a large role in the success of any nursing facility. Social workers ensure that nursing facility residents are comfortable and secure during their stay. They respond to and resolve both resident and family complaints. Social workers make changes to residents' rooms, finding private rooms for some residents as needed. Other issues include ensuring fair treatment to residents by the nursing staff and finding appropriate recreational activities for residents.

**Staff Training**

Social workers train staff on issues related to the resident and his/her family. The social worker discusses, with the nursing staff, the emotional needs of both the resident and family. In addition, the social worker may conduct training sessions on issues such as identifying physical and/or emotional abuse. Social workers may also plan interventions, as needed, for residents who display behavioral symptoms or problems.
Belknap County
67 Water St. Suite 105
Laconia, NH 03246
Local Line: 528-6945
Fax: 527-3790

Carroll County
448 White Mountain Highway,
P.O. Box 420,
Chocorua, NH 03817
Local Line: 323-2043
Fax: 323-7508

Coos County
610 Sullivan St., Suite 6
Berlin, NH 03570
Local Line: 752-6407
Fax: 752-1824

Grafton County
Lebanon
10 Campbell St.,
P.O. Box 433
Lebanon, NH 03766
Local Line: 448-1558
Fax: 448-6920
Littleton
Mt. Eustis Commons,
262 Cottage St. Suite G-25
Littleton, NH 03561
Local Line: 444-4498
Fax: 444-0379

Plymouth Satellite: 536-3056

Hillsborough County
Manchester
555 Auburn St.
Manchester, NH 03103
Local Line: 644-2240
Fax: 644-2361
*Nashua
70 Temple St.
Nashua, NH 03060
Local Line: 598-4709
Fax: 598-8491

Merrimack County
2 Industrial Park Drive PO Box 1016 Concord, NH 03302-1016
Local Line: 228-6625
Fax: 228-6623

Monadnock Region (Cheshire County)
105 Castle St. Keene NH 03431
Local Line: 357-1922
Fax: 352-8822

Rockingham County
Seacoast
270 West Rd., Unit 1A Portsmouth, NH 03801
Local Line: 334-6594
Fax: 334-6596
Salem
287 Lawrence Rd.
Salem, NH 03079
Local Line: 893-9769
Fax: 893-1339

Strafford County
1 Old Dover Road. Suite 6,
Rochester, NH 03867
Local Line: 332-7398
Fax: 335-8010

Sullivan County
1 Pleasant St. Ste 105
(Corner of pleasant and Sullivan)
Claremont, NH 03743
Local Line: 542-5177
Fax: 542-2640
LCA Contact Checklist
Section Q Referral

Name: __________________________ Initial Nursing Facility meeting: __________

Date of initial contact with NF ___________________ Tentative follow-up meeting: __________

<table>
<thead>
<tr>
<th>Information From Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Information on the Resident</td>
</tr>
<tr>
<td>Name: __________________________</td>
</tr>
<tr>
<td>DOB: __________________________</td>
</tr>
<tr>
<td>Marital Status: __________________________</td>
</tr>
<tr>
<td>How long has the Individual been a resident in the Nursing Facility? __________________________</td>
</tr>
<tr>
<td>Is there a guardian?</td>
</tr>
<tr>
<td>Is there a Power of Attorney?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Primary and Secondary medical diagnosis: __________________________</td>
</tr>
<tr>
<td>Briefly describe the basic condition(s) of the resident: - (ex. What type of services are being provided to the resident –nursing/PT etc. Any potential complications to be aware of – ex. On going mental health issues)</td>
</tr>
<tr>
<td>What is the best way to contact the resident / guardian? __________________________</td>
</tr>
<tr>
<td>When is the best time to visit? __________________________</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Individuals present at meeting with resident?</td>
</tr>
<tr>
<td>Where were you living before the nursing home? (location, type of residence, with whom)</td>
</tr>
<tr>
<td>Did you have any type of assistance in the home? (ex. Home Health Aides, homemaker)</td>
</tr>
<tr>
<td>If yes, what type of assistance and how often?</td>
</tr>
<tr>
<td>What happened to initiate a nursing home stay? (ex. Was there a hospitalization prior to the nursing home and for how long)</td>
</tr>
<tr>
<td>How long have you been in the Nursing Home?</td>
</tr>
<tr>
<td>What type of care are you currently receiving? (ex. Physical therapy, Specific type of Nursing Care)</td>
</tr>
<tr>
<td>Are you able to manage most of your care without nursing home assistance? (Ex. Are you able to manage your medication, ambulation and bathing, etc.)</td>
</tr>
<tr>
<td>If No, please explain (Do you need a specific type of assistance?)</td>
</tr>
<tr>
<td>What type of assistance do you feel you may need to live in your home? (ex.: chair lift, ramp, cleaning)</td>
</tr>
<tr>
<td><strong>COMMUNITY INFORMATION</strong></td>
</tr>
<tr>
<td>Do you have housing?</td>
</tr>
<tr>
<td>What type and with whom?</td>
</tr>
<tr>
<td>Do you need to locate housing?</td>
</tr>
<tr>
<td>What type and with whom?</td>
</tr>
<tr>
<td>What type of assistance do you feel you may need to maintain your home? (ex.: fuel assistance, yard work)</td>
</tr>
<tr>
<td><strong>Post Visit</strong> (If during your visit, the individual requests additional information, provide a timeline for a follow-up visit.)</td>
</tr>
<tr>
<td>Follow-up visit:</td>
</tr>
<tr>
<td>OTHER:</td>
</tr>
</tbody>
</table>
MEDICAID

NH Medicaid is a federal and state funded health care program that serves a wide range of needy individuals and families who meet certain financial and/or medical eligibility requirements. The program works to ensure that eligible adults and children have access to needed health care services by enrolling and paying providers to deliver covered services to eligible recipients.

Medicaid provides payment for health care services ranging from routine preventive medical care for children to institutional care for the elderly and disabled.

Covered services can include:

- Hospital, physician, nursing facility, home health, lab, x-ray, family planning, rural health clinics, prescription drugs, physical-occupational and speech therapy, adult medical day care, medical transportation, medical supplies, durable medical equipment, dental, psychotherapy, podiatry, interpreter, advanced registered nurse practitioners, certified midwife, private duty nursing, EPSDT (early periodic screening and diagnostic testing) newborn home visits, extended services to pregnant women, personal care attendant, vision care, audiology, nursing facility, home and community based care for the elderly.

The program also covers services for developmentally disabled individuals and persons with acquired brain disorders, as well as services at community mental health centers.
What is Medicare?

Medicare is a national social insurance program administered by the Federal Government. Medicare is provided to the following:

- People 65 or older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) which is a permanent kidney failure requiring dialysis or a kidney transplant

There are four different parts to Medicare which cover specific services:

**Medicare Part A (Hospital Insurance)**
- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice and home health care.

**Medicare Part B (Medical Insurance)**
- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care
- Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse

**Medicare Part C (Medicare Advantage)**
- Offers health plan options run by Medicare-approved private insurance companies
- Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include extra benefits for an extra cost

**Medicare Part D (Medicare Prescription Drug Coverage)**
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future
- Run by Medicare-approved private insurance companies

Medicare does not cover everything. You may need certain services that Medicare does not cover. These services may need to be paid by you or if you have other insurance which may cover the cost or you are in another Medicare Health plan which covers the cost. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance and copayments.

**Some items and services not covered by Medicare are:**
- Long-term care
- Routine Dental Care
- Dentures
- Cosmetic Surgery
- Acupuncture
- Hearing aids
- Exams for fitting hearing aids
Resource Links

- Center For Medicare & Medicaid/ Nursing Home Quality Initiative
  http://www.cms.gov/NursingHomeQualityInitiatives

- New Hampshire Health Facilities Administration
  http://www.dhhs.nh.gov/oos/bhfa/index.htm

- New HamH Division of Community Based Service (BEAS)
  http://www.dhhs.nh.gov/dcbcs/index.htm

- The National Ombudsman Resource Center (general MDS 3.0 Section Q information for Long Term Care Ombudsman):
  http://www.ltcombudsman.org/issues/MDS-3.0

- New Hampshire ServiceLink Aging & Disability Resource Center
  www.servicelink.org

- Granite State Independent Living, Inc
  http://www.gsil.org

- Nursing Home Social Worker Association of NH
  http://www.nhswanh.org

- Look Back, Plan Forward
  http://www.lookbackplanforward.com

- CMS Community Living Initiative webpage:
  http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage

- Additional Section Q training materials and tools can be found at the MFP Technical Assistance Webpage at
  http://mfp-tac.com/

- You tube link with tag line: For two individual’s perspectives on returning home after residing in a nursing home see “Gladys & Linda Return to the Community” video at:
  http://www.youtube.com/watch?v=vfCSd9eK9F0

- Person-centered Dementia Care: A Vision to Be Refined